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**The Evolving Role of the Healthcare
Assistant and its Implications for
Regulation in the Republic of Ireland – A
Case Study Approach**

Patrick Glackin

Professional Doctorate

2016

**The Evolving Role of the Healthcare
Assistant and its Implications for
Regulation in the Republic of Ireland – A
Case Study Approach**

Patrick Glackin

A thesis submitted in partial fulfilment of the
requirements of the University of
Northumbria at Newcastle for the degree of
Professional Doctorate

Research undertaken in Newcastle Business
School

December 2016

Abstract

Healthcare assistants (HCAs) have been a longstanding feature of the Irish health service workforce albeit under different guises such as nursing auxiliary or nursing aide. However, concerns have been growing about this workforce since scandals in the UK (Winterbourne View and Mid-Staffordshire) and Ireland (Aras Anghara) reported appalling standards of care being administered by unregulated care assistant staff members to vulnerable adults in residential settings. Whilst recognising these concerns and acknowledging that the role continues to evolve and grow in significance from a policy perspective no proposal has been posited for the professional regulation for this occupational group. The purpose of this study is to explore the changing role of Healthcare Assistants in Ireland and to consider the potential need for professional regulation in the public interest.

This thesis makes use of two central theories proposed to explain the pattern and motivation of professional regulation in healthcare, public interest theory and public choice theory.

An explorative in-depth case study approach combining a number of different data-gathering methods, including focus groups with HCAs, semi-structured interviews with senior managers and other key stakeholders and document analysis, was adopted. The findings reveal the existence of a three tiered HCA workforce – qualified, part qualified and unqualified that is a source of confusion at the interface between HCAs and registered nurses for delegated tasks and subsequently viewed as a risk to patient safety.

This study makes a valuable contribution to a neglected area of knowledge by presenting for the first time the views of HCAs and senior managers regarding professional regulation for the evolving HCA workforce in Ireland. The study also makes a valuable contribution to practice by developing a series of recommendations regarding regulation and governance of the HCA workforce.

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Declaration

I declare that no outputs submitted for this degree have been submitted for a research degree of any other institution. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this commentary has been approved. Approval has been sought and granted by the Faculty Ethics Committee on 22nd April 2014 and the Ethics Committee of the health service in Ireland on 26th September 2014.

I declare that the Word Count of this Thesis is 65,713.

Name: Patrick Glackin

Signature:

Date: 12th December 2016

Glossary

ABA	An Bord Altranais
CNM	Clinical Nurse Manager
EU	European Union
FETAC	Further Education and Training Awards Council
HCA	Health Care Assistant
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
INMO	Irish Nurses and Midwives Organisation
MTA	Multi-task Attendant
NHS	National Health Service
NMBI	Nursing and Midwifery Board of Ireland
PSA	Professional Standards Authority
RTE	Raidió Teilifís Éireann
SIPTU	Services Industrial Professional and Technical Union
QQI	Quality Qualifications Ireland

Chapter 1 Introduction and Context

1.1 Introduction

This thesis examines the requirement and extent of professional regulation for healthcare assistants in Ireland and in particular focuses on the concept of public protection. The focus of the research is on the evolving role of the healthcare assistant (HCA); preparation for the HCA role; the impact of the role on quality and patient safety; HCAs' access to patient information and the perceived value of professional regulation for HCAs and the public.

These themes will be explored through the theoretical lens of public interest theory and the public choice theory. Public interest theory declares that regulation will serve the wider public interest whilst public choice theory contends that regulation often serves private interests only and regulators can be captured by the very people they are supposed to regulate. I examine the validity of both sides of these theoretical constructs in the context of exploring the requirement for healthcare assistant regulation.

I commence this chapter by defining the role of the healthcare assistant in Ireland. This is followed by an outline of the context, underpinning rationale and background justification for undertaking the study. I then set out the overall impetus for choosing to undertake research in the area of professional regulation for healthcare assistants in Ireland. This is followed by an overview of the research aim and research objectives. This first chapter introduces the reader to some of the key aspects of the study and to some elements of the theory that are then developed in the literature review. The chapter concludes with a logical sequence of each of the study chapters to familiarise the reader with the thesis.

1.2 Definition of Healthcare Assistant

The Department of Health and Children (DoHC), Ireland have defined the role of the HCA as:

...to assist nursing/midwifery staff in the delivery of patient care under the direction and supervision of the Clinical Nurse Manager 2/ 1, Staff Nurses/ Midwives/ Public Health Nurses and community Registered General Nurse as appropriate. (DoHC, 2001: 25)

This definition has been adopted for the purpose of this thesis. Healthcare assistants (HCAs) are employed in a variety of clinical settings, working in hospitals, community or GP surgeries, under the guidance of a qualified healthcare professional. The role can be varied depending upon the healthcare setting (Kessler, et al., 2012). HCAs go by many titles and are largely unregulated, which contributes to the relative invisibility of this workforce in the eyes of researchers, policy makers, patients and the public at large (Hewko, et al., 2015; Thornley, 2000).

Whilst acknowledging that nursing and midwifery are two separate professions in Ireland, for the purposes of brevity throughout the rest of this paper I will use the term ‘nursing’ for both professions.

1.3 Context

Developed countries are experiencing increasing pressures on their healthcare services as a consequence of extended longevity and the resultant demographic shift to an ageing population; spiralling costs; increased patient expectations; and shortages of skilled healthcare professionals (Bosley and Dale, 2008). In Ireland, these challenges are no different with a growing population exhibiting increasingly complex healthcare needs (Barrett, et al., 2011), austerity measures implemented in recent years (Scott, et al., 2013), reduced staffing levels and current difficulties in recruiting and retaining healthcare professionals (Department of Health, 2014a; Department of Health, 2016a). The picture presented points to a problematic, extremely costly and unsustainable future for the health services in Ireland. In response to these challenges, the Government of Ireland is committed to reforming our model of delivering healthcare, from the inefficient existing hospital centric system so that more care is delivered in the community. Therefore, this study is being conducted at a moment in time when the health service is undergoing unprecedented structural reform in a drive towards a new model of healthcare delivery. This will require a redesign of the workforce to include a review of skill mix and staffing levels and an emphasis on building capacity in the community (Department of Health, 2012). Consequently, in a drive for greater efficiencies, employers in the Irish health service are increasingly drawn to HCAs as part of the overall grade mix in the nursing care teams.

Healthcare assistants (HCAs) have been a longstanding feature of the Irish health service workforce albeit under different guises such as nursing auxiliary or nursing aide. The role of the healthcare assistant was brought to the forefront in 1998 when the Report of The Commission on Nursing ‘A blueprint for the future’ was published. The Commission recommends ‘...*that health service providers, nursing and midwifery management and nursing organisations examine opportunities for the increased use of care assistants and other non nursing personnel in the performance of non-nursing tasks*’ (Government of Ireland, 1998: 90).

Furthermore, the role of the HCA continued to gain traction arising from changes in the educational process for qualified registered nurses and the Government’s response to the transposition into Irish law of the European Working Time Directive in 2004. A further reason to account for the increasing prominence of the HCA role is the economic crash in 2008 which signalled the beginning of an extended period of austerity requiring a refocus on skill mix and value for money.

At the same time concerns have been growing about this workforce since scandals in the UK (Winterbourne View and Mid-Staffordshire) and Ireland (Aras Attracta) reported appalling standards of care being administered by unregulated care assistant staff members to vulnerable adults in residential settings. These scandals have placed their role under increased public scrutiny, with commentators increasingly debating the quality of training, practice, supervision and, more specifically, on whether and how the role should be professionally regulated in the public interest (Duffield et al., 2014; Mckenna et al., 2004).

Whilst much has been written about the role of the HCA in the United Kingdom and other jurisdictions, there is little research on the role within an Irish context. Moreover, there is little acknowledgement in the literature of the risk to patient safety if the healthcare assistant role remains unregulated (Griffiths and Robinson, 2010). Investigations into Leas Cross Nursing Home (2009), Mid Staffordshire NHS Trust (2013) and the Midland Regional Hospital (Portlaoise, 2014) have illuminated the role of HCA staff and prompted a discourse on the requirement for regulation of this workforce. A recently published EU commissioned report proposes that HCAs should be registered ‘...*through an organ of self-administration of the occupational group or a state agency*’ (Braeseke et al, 2014: 60).

However, the question of regulation of healthcare assistants is a subject over which there are strongly held opinions and one in which many stakeholders have vested interests, including trade unions, regulatory bodies, employers, service user organisations and governments. Whilst recognising these concerns and acknowledging that the role continues to evolve and grow in significance from a policy perspective no proposal has been posited for the professional regulation for this occupational group. This may be explained in part by the absence of a national representative voice to lobby on behalf of the workforce. The emergence of the Healthcare Assistants' Committee in the SIPTU Trade Union and the formation of the Association of Health Care Assistants in Ireland (AHCAI) may present a platform for a rational discourse in respect of professional regulation and other issues relating to the HCA role. It is against this context that this study addresses the need to examine the requirement for the professional regulation of HCAs in the Republic of Ireland.

This is the first study in Ireland to examine the requirement for professional regulation of the HCA workforce. The findings will be of relevance to regulators, policy makers and management of the Irish healthcare service. Regulation itself is defined as:

a principle, rule or law designed to control or govern conduct. It is often defined as rule-making and rule enforcement. It occurs when an external agency imposes standards or rules on the behaviour and actions of others, which are accompanied by enforcement provisions. (Health and Social Care Regulatory Forum, 2009: 4).

Recent years have seen a growing emphasis on regulation and inspection in Ireland with a stronger focus on public protection. The implementation of the Health and Social Care Professionals Act in 2005, the Health Information and Quality Authority in 2007, and the Nurses and Midwives Act in 2011 are evidence of a shift towards greater regulation. A series of high profile inquiries has therefore motivated sweeping reforms of healthcare professional regulation in Ireland (doctors, nurses, midwives, allied healthcare) in order to create a more transparent and accountable system.

1.4 Researcher Interest

The stimulus for my study stems from an academic interest in professional regulation and from a long-term involvement in the development of the HCA role in the Irish health service. In 2003, an initiative to address the education, training and development needs of

32,000 support staff in the Irish Health services was established arising from an industrial relations agreement between the Department of Finance, Department of Health and Children, Health Service Executive (HSE) and the trade union SIPTU. This initiative became known as the SKILL (Securing Knowledge Intra Lifelong Learning) Programme (Ernst and Young, 2011). In my role as Director of Nursing and Midwifery Planning and Development, I was the nominated lead person to provide a link between the SKILL Programme and the services nationally to ensure robust governance and accountability processes were in place for the training of healthcare assistants. I therefore have a historical connection to the early development of these roles in Ireland. The theme of this research is therefore intimately associated with my ongoing work and an important stimulus for conducting this research. I considered that the question of professional regulation for healthcare assistants in Ireland was worthy of more in depth consideration because of the expansion of the role and a greater emphasis on patient safety and public protection.

1.5 Aim and Objectives of the thesis

The aim of the study is:

To explore the changing role of healthcare assistants in Ireland and consider the need for professional regulation in the public interest

The objectives of the research are to:

1. Undertake an in-depth critical review of the extant published literature regarding unregistered HCA staff and the relevant discourse regarding professional regulation
2. Seek to understand the views of the healthcare assistants in respect of their changing role and subsequent future regulation for their profession
3. Assess the views of other key stakeholders in Ireland in respect of proposed introduction of healthcare assistant regulation
4. Identify the risks if any associated with this workforce continuing to provide front line clinical care while unregulated

This thesis limits its scope to that of the Republic of Ireland but will draw on experiences from the United Kingdom and other jurisdictions as relevant. Otherwise, the research aim was stated broadly enough in order to allow scope but still give direction into the exploratory nature of the study. The aim was not intended to be limiting, and the researcher recognised that the participants may raise varying concerns and observations, which the study could explore where relevant.

1.6 Structure of the thesis

Following this introduction, the thesis is structured into six chapters as follows:

Chapter 2 critically examines the extant literature in the development and ongoing evolution of the role of the HCA within an Irish context and conceptualizes the HCA role into eras based on the researcher's understanding of landmarks which either facilitated or attempted to curtail the HCA role development in Ireland. The chapter also examines the literature in respect of the nature of the relationships between the HCA and other professionals and the impact of the role on patient safety and public protection.

Chapter 3 presents the two central theories proposed to explain the pattern of professional regulation in healthcare, public interest theory and public choice theory. The chapter provides the reader with an overview of the relevant literature concerning these theories. This chapter concludes by reviewing the literature in the field of professional regulation and the current discourse in respect of regulation for HCAs.

Chapter 4 provides a discussion of the methodological approaches adopted to address the themes emerging from the literature and the objectives of the study. The researcher introduces the epistemological position that led to the selection of a qualitative research approach for this study before turning to the methodological approach of semi-structured interviews and focus group interviews. The chapter concludes by reflecting on the quality of the research design followed by some ethical considerations provoked by the overall work.

Chapter 5 presents the findings of the qualitative data analysis using five top level themes. Whilst the findings are presented as five discrete sections, it is important to note that these findings are fluid and interrelated and as such will be brought together in a broader discussion of the main findings in relation to the literature that is presented in chapter six.

Chapter 6 draws together the study findings underpinning the thesis and examines these in the broader context of the extant literature with a view to formulating recommendations for practice. This chapter demonstrates where the research findings contradict, extend, or coincide with the literature review.

Chapter 7 concludes by drawing together the threads of the thesis and offering a number of recommendations for consideration. The chapter also devotes time to discussing the contributions and theoretical implications of this study, a critical reflection as well as potential avenues of future research.

1.7 Chapter Summary

This first chapter has introduced the background and context of the study highlighting the importance of researching professional regulation for HCAs in Ireland. The researcher's interest in the topic was also outlined. In addition, the research objectives were presented followed by an outline of the structure of the thesis. The next chapter reviews the extant literature relevant to role, relationships and patient safety.

Chapter 2 Literature Review – Role, Relationships and Patient Safety

2.1 Introduction

This chapter aims to critically review extant literature relating to risks to patient safety arising from the role of the healthcare assistant (HCA) and relationships with other professionals. As acknowledged in Chapter 1, concerns have been growing about this unregulated workforce as a consequence of a series of scandals involving HCAs both in Ireland and in the UK.

The review begins with an introduction to the role of the HCA, initially examining its origins and historical development. This is followed by an examination of the evolving and expanding role of the HCA. Finally, the impact of this workforce is considered with reference to reports of recent shortcomings in care.

2.2 History and Background

Since HCAs provide direct nursing care to patients, it is crucial to gain an understanding of their work by examining their origins and historical development. This chapter conceptualizes the HCA role into eras based on events that influenced the HCA role development in Ireland (see Table 2-1 below). It draws on legislative and policy developments, which have influenced and shaped the perception of the role. It will be argued that the HCA role has become increasingly strategically significant as a vehicle for pursuing policy goals such as the implementation of European legislation, meeting the requirements of the Public Service Stability Agreement (2013-2016), and contributing to the Irish healthcare modernisation agenda. The literature will also trace and reflect how the role has been used as a:

...relief – removing routine tasks from nurses; as an apprentice – providing a future supply of nurses; as a substitute – replacing nurses in the provision of some core nursing tasks; and as a co-producer – enhancing care quality by bringing to bear distinctive capabilities. (Kessler et al., 2010: 22-24).

Table 2-1 History of Healthcare Assistants

1854 - 1856	The Crimean War is the first recorded recognition of nurse aides working as part of the broader nursing team.
1955	The nursing assistant or nursing auxiliary grade was given formal recognition in the healthcare setting in the UK.
1980	Working Party on General Nursing Report, Department of Health. A call for clarity on job titles and role identity for this occupational group.
1998	Report on Commission on Nursing recommends an increased use of care assistants in the performance of non-nursing tasks.
2001	The Department of Health and Children introduces the new HCA role together with associated training and piloted in 14 locations.
2002	Introduction of Nursing degree programme which awarded supernumerary status to student nurses and thereby no longer available as a source of unqualified labour supply.
2003	Publication of the 'Report on the National Taskforce on Medical Staffing'.
2004	European Working Time Directive transposed into Irish Law.
2005	The SKILL Programme was established to develop support staff in health services accompanied with a budget of €60m.
2006	Introduction of awareness programme for nurses and midwives together with clarification on the accountability of both the nurse/midwife and the HCA.
2008	Irish economy enters recession and an extended period of austerity commences.
2010	Public Service Agreement (Croke Park) – Emphasis on expanded roles and reviews of skill mix
2013	Second Public Service Stability Agreement (Haddington Road) - A key feature of the Agreement is the provision of an additional one thousand Intern places for healthcare assistants, multi-task attendants and support grades for the purpose of reducing expenditure on overtime and agency costs in the health sector. Greater emphasis on the role as a substitute as opposed to a relief.
2015	The HCA FETAC qualification is replaced with the Quality Qualifications Ireland (QQI) award and has the same academic value. The emergence of a national representative voice for HCAs in Ireland.
2016	National review of HCA role in Ireland to commence.

Adapted from Stokes and Warden (2004)

2.2.1 Era 1 – From Orderly to Healthcare Assistant

The concept of the unqualified healthcare support worker or healthcare assistant is not new and the origins of the role can be traced back to the Crimean War (1854-1856). It is the first recorded recognition of nurses' aides working as part of the broader nursing team (Stokes and Warden, 2004). The grade of 'nursing auxiliary' or 'nursing assistant' was formally recognised in 1955 in the healthcare setting in the UK (Thornley, 2000: 452).

In Ireland, healthcare support staff referred to as attendants and orderlies were employed in almost all hospitals in the country from the middle of the nineteenth century. By 1980 frustrations were being expressed by the nursing profession in respect of the increasing diversity of titles associated with the roles and a requirement for 'rationalisation of existing non-nursing grades'. There was, however, the perception that the roles offered the opportunity to alter the 'emphasis of nursing care from task-allocation to patient- centred' (Department of Health, 1980: 71).

Despite having all the characteristics of a nursing relief role to '*permit the optimum use of the skills of the nurse*' (ibid: 71), the same report also observes that role boundaries were blurred between both groups of staff referring to a survey of the activities of staff nurses which revealed that over 60% of the respondents were undertaking tasks that in their opinion should be carried out by attendants (ibid). This was echoed by Savage (1985), who noted that a large proportion of direct patient care was undertaken by nursing assistants.

The role of the healthcare assistant was brought to the forefront in 1998 when the Report of The Commission on Nursing *A blueprint for the future* was published. The Commission recommends '*that health service providers, nursing and midwifery management and nursing organisations examine opportunities for the increased use of care assistants and other non nursing personnel in the performance of non-nursing tasks*' (Government of Ireland, 1998: 90).

This policy document which was fully implemented also recommended the introduction of the four year degree programme for nursing to be delivered by the third level education sector. This was a significant development not only for the structure of the nursing workforce and preparation for practice, but also the strategic value that was now placed on

the HCA occupational group in terms of contribution towards workforce re-design. The Commission also examined suggestions for the regulation of care assistants but considered the '*control of care assistants and non-nursing personnel as essentially a matter for employers*' (ibid: 2).

The shifting from an apprenticeship model to baccalaureate training delivered in higher education institutes for nurses in 2002 signalled the demise of the student nurses' availability as a source of unqualified labour supply. The introduction of this new training meant that nursing degree students were awarded supernumerary status (Keeney et al., 2005). In response, the Department of Health and Children opened the door for a new category of support worker – the HCA – to work under the direct supervision of nurses (Department of Health and Children, 2001).

This was followed by a wealth of discourse involving trade unions, health service managers and policy makers debating the proposed role and function of HCAs, preparation for the role and subsequent supervision of these assistants.

2.2.2 Era 2 – HCA Training

The introduction of the HCA grade was also accompanied by formal training of this group of workers. The Healthcare Support Certificate training programme was developed by the Further Education and Training Awards Council (FETAC) and piloted specifically for HCAs in 2001 – 2002 (Flood, 2008). This vocational training was the key distinguishing factor between the traditional nurse attendant and the contemporary health care assistant role. The successful candidates were awarded a level five certificate on the National Framework of Qualifications (NFQ) which is a system of ten levels. Each level is based on nationally agreed standards of knowledge, skill and competence. This framework was intended to establish progression routes and clearer pathways between academic education and vocational training. A Level 5 Certificate enables learners to develop a broad range of skills, which are vocational specific and require a general understanding of the subject matter (Further Education and Training Awards Council, 2005).

The programme was evaluated by McKenna et al. (2003) with a key recommendation to continue to develop and extend the training for healthcare assistants across Ireland.

The training for HCAs was delivered primarily but not exclusively through the Centres of Nursing and Midwifery Education (CNMEs). The CNMEs successfully transitioned from schools of nursing following a recommendation in the Commission on Nursing and the introduction of the graduate professions for nursing and midwifery (Government of Ireland, 1998). These twenty-three Centres were now responsible for the provision of continuous professional development to the nursing workforce in the public service in addition to the training of HCAs.

In 2005, the SKILL Programme office was established in the Health Service Executive (HSE) to provide oversight and funding to the sum of €60m over five years for the provision of the FETAC level 5 programmes to HCAs and other support staff (Ernst and Young, 2011).

It was anticipated that this training would enable clearer differentiation between the registered and non-registered nurse role. However, in 2005, a high level group which was established to examine the outstanding recommendations contained in the report on the Effective Utilisation of Professional Skills of Nurses and Midwives (DoHC, 2001) had to provide further clarification on the accountability of both the nurse and the HCA. Consequently, this high level group proposed an educational awareness programme for nursing staff on the content of the training, the role of the HCA as support for the nurse and the principles of effective delegation of tasks (HSE, 2006). The lack of clarity in the HCA role was further compounded by the absence of a nationally agreed job specification at implementation stage, which was a major flaw. This was eventually addressed by the aforementioned high-level group (ibid, 2006).

The HCA was viewed as having a key relief role by the high level group in the delivery of fundamental care to patients and carrying out a limited range of routine clinical tasks under the supervision of a registered nurse. As such, the Activities of Living Patient Care Module was agreed for implementation (ibid, 2006).

The FETAC Level 5 HCA training also opened up a pathway into professional nurse training. The Department of Health and Children launched a sponsorship scheme in 2002 for health care assistants and ward attendants wishing to train as nurses to coincide with the implementation of the four-year pre-registration nursing degree programme. The scheme made available 40 sponsorships per annum and successful applicants could retain

their existing substantive salary throughout the four-years of the nursing degree programme (Department of Health and Children, 2002).

The HCA training was fully endorsed by the newly formed Health Information and Quality Authority (HIQA) in its published Standards for Residential Care Settings for Older People in Ireland. The Standards which are underpinned by legislation required that *‘all newly recruited care staff and those in post less than one year commence training to FETAC Level 5 or equivalent within two years of taking up employment’* (Health Information and Quality Authority, 2009: 42).

2.2.3 Era 3 - From European Working Time Directive (EWTD) to Transformation

The European Directive on Working Time was issued on 23rd November 1993. The main provisions of the Directive were to limit maximum hours of working, and establish minimum entitlements to rest periods and paid annual leave for most workers in the EU. On 22nd June 2000, the provisions of the EWTD were extended to include the activities of doctors in training referred to as non consultant hospital doctors (NCHDS). The EWTD was transposed into Irish law and subsequently came into operation on the 1st August 2004 (Health Service Executive Employers Agency, 2007: 4).

In 2002, the minister for Health and Children established the ‘National Taskforce on Medical Staffing’ to devise an implementation plan for substantially reducing the average working hours of NCHDs to meet the requirements of the EWTD. Among the proposals the report highlighted a need to examine the current health care professionals’ roles which included opportunities for role expansion for nurses and by extension further development of HCA roles. The Task Force acknowledged that *‘the grade offers significant scope to support nurses and midwives in their work and enable them to concentrate on the more specialist tasks for which they have been trained’* (Department of Health and Children, 2003a: 13).

The Chief Nursing Officer in the Department of Health and Children responded by setting up a steering group in 2003 to examine and re-define nursing roles which would liberate the potential for these clinicians to become autonomous practitioners and manage a caseload with admission, discharge and prescribing privileges (Department of Health and Children, 2003b).

This was a significant development in the advancement of nursing into traditional domains of medical practice and, by extension, health care assistants' expansion into customary roles of nursing. The traditional domains of practice of health care professions were therefore being questioned and role blurring was becoming evident.

In 2007, the HSE launched its ambitious four year 'Transformation Programme' with an emphasis on easy access for everybody to high quality care and services; ensuring people have confidence in the service and instilling staff pride (HSE, 2007, p. 9). The strategy also outlined the major challenges that lay ahead to include an increasing population, an ageing demographic, and an escalation in chronic illness. The direction of development was clear to ensure we do not '*pass to the next generation a dysfunctional and very expensive system*' (ibid: 5). Underpinning this vision was the principle of value for money and a refocus on skill mix.

2.2.4 Era 4- From Economic Collapse to Future Health

In 2008, the Irish economy witnessed the beginning of an economic crash that signalled an extended period of austerity. This resulted in the health service budget being reduced by 22% between 2008 and 2013. Consequently, this provoked discussions about staffing costs and the financial implications of all staff were scrutinised. During this period the workforce was reduced by 11% (HSE, 2013).

The healthcare support roles were now moving centre stage with less of an emphasis on a relief role for professionals and a stronger public policy focus on their roles as substitutes. Replacing nursing hours with healthcare assistant hours in the composition of the nursing workforce is not uncommon during periods of financial constraints (Kessler et al., 2010).

The Public Service Agreement (2010) (Croke Park Agreement) covering the period 2010-2014 was a commitment by public servants and their managers to work together to change the way in which the Public Service conducted its business so that both its cost and the number of people working in the Public Service could fall significantly, while continuing to meet the need for services and improve the experience of service users.

Within the Agreement a number of measures were proposed which included further expansion of health professional roles and a review of rostering and skill mix arrangements paving the way for opportunities for HCA development.

A second Public Service Stability Agreement (2013), commonly referred to as the Haddington Road Agreement (HRA), was entered into between the social partners and Government in May 2013. This latest deal, made up of a series of bilateral agreements between the government and individual public service unions replaced the original Croke Park Agreement with the aim of trimming back the public service bill by €1 billion by end of 2016. A key feature of the Agreement is the provision of an additional one thousand intern places for healthcare assistants, multi-task attendants and support grades for the purpose of reducing expenditure on overtime and agency costs in the health sector (Labour Relations Commission, 2013).

In response to the HRA Agreement, the HSE produced an implementation plan to meet its own commitments under the Agreement. It is clearly evident throughout the plan that a significant reduction in agency and overtime staff is a primary target. The Report envisages the direct replacement of agency nursing staff with intern HCAs in order to change the skill mix and reduce costs in Disability and Older People residential services (Health Service Executive, 2014a). This use of the HCA as a flexible and lower cost substitute for nursing has outraged the largest nursing and midwifery trade union, the Irish Nurse and Midwives Organisation (INMO), referring to the proposals as a ‘...slash-and-burn approach to the Irish public health service [which] ...*is damaging, corrosive, indefensible and cannot be continued by the Government*’ (Irish Independent, 2014).

The HCA is now perceived as having an increasingly significant role in the delivery of fundamental care to patients and carrying out a range of routine clinical tasks. Some even view the HCA as replacing the registered nurse as the predominant carer because of the increasing emphasis on administrative responsibilities and co-ordination of care on the part of the nurse (McKenna et al., 2004). This also suggests that HCAs will have a distinctive contribution to make to the overall provision of healthcare by bringing unique qualities to the multidisciplinary team approach which Kessler et al., (2010: 138) refers to as ‘co-producers’ of care.

Whilst the role continues to evolve and grow in significance, from a policy perspective there is as yet little debate on the question of professional regulation for this occupational group in Ireland. However, a recently published EU commissioned report (Braeseke, 2014: 60) proposes that HCAs should be registered ‘...*through an organ of self-administration of*

the occupational group or a state agency'. The Irish situation may be explained in part by the absence of a national representative voice to lobby on behalf of the workforce. The emergence of the Healthcare Assistants' Committee in the SIPTU Trade Union should present a platform for a discourse in respect of professional regulation and other issues relating to the HCA role. Furthermore, a national review of the HCA role in Ireland has recently commenced following a recommendation in the Interim Report and recommendations by the Taskforce on Staffing and Skill Mix for Nursing in medical and surgical settings in acute hospitals (Department of Health, 2016a). The national FETAC qualification for HCAs was re-branded as QQI (FET) award in 2015. In the context of this study both terminologies will be referenced where appropriate.

2.2.5 Summary

The development of the role from its emergence in the Crimean War to the present day has been influenced by a number of key events. It is clear from the literature that the role has progressed from being an untrained assistant to nurses, to a role that holds strategic importance for policy makers in the context of the ongoing healthcare modernisation agenda. However, there remain concerns about current Government policy which states targets to increase the number of HCAs employed in the Irish healthcare system together with labour substitution with consequential effects of blurring of traditional boundaries and continued role ambiguity. These themes will be examined further in later chapters. The next section will examine the literature associated with the evolving role of this occupational group in more detail.

2.3 Evolving Role of the HCA

In order to attempt to understand a possible application of professional regulation to the grade of HCA it is necessary to examine the evolving role of this occupational group and the associated consequences. This section will review the relevant literature associated with the evolving and extending roles of the healthcare assistant. This will include an examination of the boundaries between the HCAs and nurses and the increasing utility of the HCA role as a substitute for the registered nurse. It will be argued that the boundaries between the unregistered care worker and the professional nurse are becoming blurred and, consequently, both roles are becoming increasingly indistinguishable. In fact there are many who believe that the HCA undertakes the essence of nursing, whilst the registered nurse provides the necessary direction and supervision.

2.3.1 Expanding Role of the HCA

The evolving roles and activities of the healthcare assistants are widely debated in the literature (Thornley, 2003; Lloyd-Jones and Young, 2005; Oldfield, 2009; Berta et al., 2013). Just as nurses are expanding their practice and acquiring roles and activities that were traditionally the preserve of medical practitioners (Daly and Carnwell, 2003) so healthcare assistants are expanding their boundaries to accommodate activities that registered staff have vacated. Stokes and Warden (2004) undertook an exercise to track the evolution of the HCA role in the British healthcare system, referring to the purpose of the role as being to overcome staffing difficulties and to perform low priority and non-nursing duties (ibid). This early view found an echo with McKenna et al. (2004: 454) when observing that HCAs were initially '*...necessary to undertake the lower level duties so that registered nurses would have time to meet higher level patient needs*'. As the role emerged in 2001 in the Irish health service, it became apparent that the duties assigned to HCAs would vary in accordance with the care setting but would include the following functions:

- Assisting the patient in the activities of daily living under the supervision of a nurse/midwife;
- Assisting the nurse/midwife in the provision of quality nursing service;
- Assisting the nurse/midwife in duties associated with the delivery of care and management of the ward/healthcare environment and other support duties as appropriate (Shannon, 2001: 26).

Since their introduction, the HCA role has mushroomed and, today, they are employed in general, mental health, intellectual disabilities, children's and maternity services and work in a range of clinical areas in institutional and community settings. In addition to the HSE, HCAs are employed in a variety of organisations in the independent and voluntary sectors.

Recent studies have observed that the role now encompasses many tasks that were previously the responsibility of registered nurses and that would have been unthinkable at the time of their introduction (McKenna et al., 2004; Spilsbury and Meyer 2004; Knibbs et al., 2006; Sandall et al., 2007; Duffield et al., 2014).

In 2004, McKenna et al. undertook a critical review of the HCA role and suggested that HCAs were often coerced to extend their practice beyond their level of competencies to perform duties for which they were not trained and potentially endangering patients. This includes '*administering medication, undertaking venepuncture, recording ECGs, siting intravenous cannulae, removing venflons, leading counselling sessions, making decisions about wound dressings and when patients will be seen in A&E departments*' (McKenna et al., 2004: 457). They refer to the phenomenon of '*role creep*' in nursing as additional medical duties are accepted thereby increasing the reliance on HCAs to fill nursing care gaps (ibid: 456). However, they caution that this increasing reliance on HCAs raises serious quality and safety questions.

Meanwhile, also writing in 2004, Spilsbury and Meyers report similar findings, but also refer to examples of HCAs being requested to undertake activities that were beyond the 'accepted' HCA role or without receiving the necessary training for the task (Spilsbury and Meyers, 2004: 415). The authors refer to these patterns as the 'misuse of HCAs' and include tasks such as blood glucose monitoring and assisting in operating theatre which result in the exploitation of this workforce (ibid: 415).

A further example of the extension of the HCA role is their involvement in the training of student nurses whilst on clinical placement (Thornley, 2000; O'Driscoll et al., 2010). Hasson et al. (2013) expressed concerns for this practice and believe it is an inappropriate utilisation of the HCA role and furthermore will stifle the learning opportunities of the student nurse. Moreover, there is growing concern that the nurses of the future are presently learning outmoded or poor practices from unqualified and unregulated staff (ibid: 2013).

However, this suggestion that HCAs are unqualified has been questioned in the literature (Thornley, 2000; Bach et al., 2008) with the introduction of the NVQ training in the UK and the FETAC training in Ireland. Nevertheless, several studies have indicated that HCAs have expanded their roles over the years, without the required theoretical underpinning and thus beyond their competency (Edwards, 2005; Hampton 2005; Lloyd-Jones and Young, 2005). As well as compromising patient safety, expanding practices without the associated upskilling can lead to HCAs feeling morally pressurised and exploited in the interest of realising superficial cost savings for the organisation (Oldfield, 2009).

More worrying, however, is the opportunistic behaviour of some eager HCAs to *'perform tasks beyond their remit, without the registered professional's knowledge'* (Hasson and McKenna, 2011: 408). Thornley (2000) reported that HCAs themselves have suggested that they sometimes perform extended tasks unofficially and therefore do not inform the registered nurse in charge. Such concerns are echoed in a multi-method study conducted by Kessler et al. (2010). The authors noted the aspirational HCAs who actively sought to extend their own roles were potentially creating problems for their wards as they were consequently neglecting core care activities (ibid).

These concerns are further amplified by findings from studies that claim that HCAs frequently work alone, caring for frail, elderly and vulnerable patients with minimal or no supervision from the registered nurse (see Badger et al., 1989; Bach et al., 2012; Tourangeau et al., 2014). This assertion finds particular applicability within the Irish health service as an equivalent unregistered assistant grade 'Home Help' staff currently provide direct personal care to patients unsupervised within their own homes. Spilsbury et al. (2013) noted that senior managers in the UK requested that responsibilities delegated to HCAs who work unsupervised in people's homes should be risk managed, with appropriate clinical governance arrangements in place.

Some commentators have been critical that registered nurses have become de-skilled in the provision of caring functions to the point that *'nursing is under threat and could pass away, to be replaced by technicians, minimally educated healthcare assistants and unqualified healthcare workers'* (Shields and Watson, 2007: 70). Moreover, Spilsbury et al. (2013: 49) reported in their study that *'...there was now a sense in which assistants were perceived by patients as more approachable and (perhaps) on a level to be able to engage with their concerns'*.

Meanwhile, nursing policy makers and regulators in Ireland have reaffirmed the uniqueness and essence of the nurses' role with statements such as *'...nurses and midwives who are competent, safety-conscious and who act with kindness and compassion provide safe, high-quality care'* (Nursing and Midwifery Board of Ireland, 2014: 20). Furthermore, the Office of the Chief Nursing Officer, Department of Health, Ireland in collaboration with the main employer (HSE) and the regulator of nursing and midwifery (NMBI) launched a policy paper to reaffirm the professional nursing and midwifery core values of care, compassion and commitment (Department of Health, 2016b). It served as a reminder

to these professions that the aforementioned values represented the essence and cornerstones of nursing and midwifery practice in Ireland. However, as ‘value for money’ policies continue to dominate the provision of healthcare in Ireland and managements’ ongoing desire to reduce labour costs (Public Service Stability Agreement, 2013) unregulated HCAs will remain prevalent in the delivery of essential care.

2.3.2 Deployment of HCA as a substitute

An underlying theme to this study relates to more longstanding policy debates that revolve around shortfalls in nurse labour supply together with cost containment strategies whilst striving to meet the on-going demand pressures for enhanced healthcare delivery. One mechanism by which to relieve this tension is to substitute between healthcare worker-groups through role substitution.

Role substitution and measures to reshape the nursing workforce in Ireland was initially raised in the Interim Report on the Commission on Nursing (1997: 15) which suggested that *‘in a tightening labour market there is likely to be a re-assessment and re-evaluation of professional roles and consideration to the concept of ‘substitution’ and ‘redistribution of tasks’ of nurses’*. This view was later challenged by the Department of Health (2001: 11) in the ‘Effective Utilisation of Professional Skills of Nurses and Midwives Irish Report’ outlining that:

There is no substitution for the skilled expertise of the qualified nurse who must remain central to the assessment, planning, implementation and evaluation of patient-care and to the supervision and delegation of all activities related to patient-care.

However, despite these warnings, current policy today both states targets to increase the numbers of HCAs employed in the Irish Public Healthcare system and encourages labour substitution (HSE, 2014a). Previous studies have confirmed this policy direction suggesting that HCAs are replacing registered nurses (Bach et al., 2008; Kessler et al., 2010; Cavendish, 2013).

The issue of skill substitution in Ireland and elsewhere centres on the debate relating to the optimal proportion of registered nurses versus un-registered staff members within care teams. Publications on skill mix are plentiful in number and predominantly from the USA.

As the debate around the role substitution by HCAs grows louder there remains significant unease among commentators in respect of skill mix strategies and the ongoing attempts of HCAs to make claims on the work of nurses (Spilsbury and Meyer, 2005; Aiken et al., 2016).

McKenna et al. (2004) present evidence in their discussion paper that HCAs are increasingly involved in non-supervised direct patient care, performing duties beyond their level of competencies and consequently infiltrating what was previously acknowledged as the registered nurses' occupational domain; all of which raises serious quality and safety questions.

Hogan (2006) conducted a small scale explorative study to identify the reasons for the paucity of patient monitoring on acute general wards. The study was undertaken in the context of the introduction of an Early Warning System to support the early detection of patients at risk of developing a critical illness. Concern was expressed that the monitoring of the vital signs of patients was being devolved to HCAs and consequently subtle changes in a patient's condition which the registered nurse may identify can go undetected resulting in further deterioration of the patient's condition (ibid).

The author found it disconcerting that qualified nurses would delegate critical patient monitoring duties to HCAs despite being unsure of their level of competence (Hogan, 2006). This qualitative study was only undertaken in one UK hospital and therefore limitations exist in respect of generalising the results. Nevertheless, it does have some application within the Irish context as the Early Warning System training and practice has been recently extended to include HCAs in Ireland (McLoughlin, 2014).

Other studies conducted by Hyde et al. (2005), Nancarrow and Borthwick (2005) and Thornley (2008) point to the degradation and cheapening of nursing care through role re-design with HCAs being substituted for registered nurses.

Department of Health UK (2012) also expressed disquiet in respect of the substitution strategies employed at Winterbourne View Hospital, which cared for adults and children with intellectual disabilities. A Panorama programme reported appalling standards of care being administered by unregulated care assistant staff members to vulnerable adults in this residential setting. The subsequent report observed that '*although structurally a learning*

disability nurse-led organisation, it is clear that Winterbourne View had, by the time of filming by Panorama, become dominated to all intents and purposes by support workers rather than nurses' (Department of Health UK, 2012: 15).

Many commentators have expressed concern that there is little difference between the roles of the registered nurse and the HCA with the exception of medication administration and patient assessment (Workman, 1996; Thornley, 2000; Kessler et al., 2010). In fact, Oldman (2009: 68) goes further and suggests that even patient assessment is no longer the sole prerogative of the nurse citing a study by Lloyd-Jones and Young (2005) whereby *'HCAs were making decisions about wound care options without reference to nurses'*.

Consequently, such fears lead McKenna et al. (2004: 457) to conclude that nurses could *'lose their claim to the core skills associated with nursing'*. It is such a concern which prompted the Irish Nursing and Midwifery Organisation to warn against the use of HCAs as substitutes for nurses (INMO, 2016).

However, not all commentators share these views, in particular, McIntosh and Holland (2012) proposed greater empowerment for HCAs with regard to decision-making, patient assessment and patient advocacy. Furthermore the authors attacked what they perceived to be influential elements within nursing that were engendering protectionism for their own profession (ibid). Interestingly from a patient perception perspective Spilsbury et al. (2013: 49) posited that assistants were *'more approachable than their professional counterparts and on a level to be able to have meaningful engagement'*.

Other studies examining the value of employing assistants as substitutes for nurses include the systematic review by Munn et al. (2013) of qualitative evidence regarding the appropriateness of strategies used to establish the health assistant role as a recognised delegated clinical role and to promote their inclusion in models of care. The authors conclude that the literature is positive towards the concept of role expansion and substitution for assistant grades but cautions that barriers exist to these strategies to include lack of clarity regarding roles and negative perceptions of assistants by registered staff. It was disappointing however; that the review only included ten studies and none of these had a stated philosophical position.

Overall, the literature demonstrates that HCAs can make a valuable contribution to patient care; however, there remain concerns and challenges that need to be considered within the

Irish healthcare system regarding the deployment of a HCA as a substitute for a registered nurse and the uncanny similarities that can exist between both roles.

2.3.3 Role

The discourse in this section of the literature review has so far focused on the expanded role of the HCA and the increasing utilisation of the grade as a substitute for the registered nurse. The following contribution from literature will reiterate these themes and magnify the concerns expressed by commentators regarding poorly defined occupational boundaries and subsequent role blurring between HCAs and registered nurses.

Uncertainty and confusion of role definition and role boundaries across registered and non-registered nursing staff are well rehearsed (Perry et al., 2003; Knight et al., 2004; Boyd, 2008). Lack of role clarity can lead to reduced productivity, arising from poor job satisfaction, higher staff turnover affecting both assistants and healthcare professionals and exploitation of HCAs (Hasson and McKenna, 2011).

In a study of establishing role clarity in clinical governance for members of boards in Irish healthcare, Boyd (2008) reported that role confusion was a key contributory factor in several recent healthcare scandals. Boyd further claims that good clinical governance is impossible in the absence of role clarity between healthcare workers at all levels and has serious consequences for patient care outcomes.

The current confusion surrounding the roles and titles used to describe healthcare assistants is uniquely challenging and contributes to the difficulty in defining the nature and boundaries of these roles, and consequently leads to further confusion regarding appropriate delegation (British Association of Critical Care Nurses, 2003). The term 'healthcare assistant', currently as used in the Irish context, has many equivalents throughout the literature. In the United Kingdom, the unregistered assistant is referred to as generic support worker, clinical support worker, healthcare support worker, care team assistant, nursing assistant, ward assistant, community care worker, home carer, scientific helper, doctor's assistant and even bed maker (Thornley, 2000). Furthermore, supporting literature from Canada highlights the use of up to 56 alternative terms for HCAs (Hewko et al. 2015: 2).

Moran et al. (2010) presented evidence that the role of the HCA is highly context specific and therefore largely defined by the tasks allocated to them locally by registered nursing staff. The range and complexity of tasks delegated to HCAs is likely to influence their work boundaries. This ad hoc practice not only contributes to national variations but also site specific variations in the deployment and development of assistant staff suggesting that there may not have been a uniform expansion of these roles, thereby further adding to the existing confusion.

Further heightening concerns of confusion, the literature suggests that patients or families may frequently find it difficult to make a clear distinction between nurses and healthcare assistants (British Association of Critical Care Nurses, 2003; Sadler-Moore 2009). This can result in a HCA being requested to undertake tasks or respond to questions from patients or families that is beyond their level of competence (Devlin and McIlfatrick, 2010). A further example arising from the perceived similarities between the HCA and nurse's role are reports that student nurses are approaching HCAs to be taught fundamental nursing skills (O'Connor, 2007; Hasson et al., 2013). To further compound the confusion and role ambiguity, it is not uncommon for pre-registration student nurses to moonlight as HCAs, sometimes for the organisations in which they currently undertake their training (McKenna et al., 2006). Having a student and an HCA role simultaneously only contributes to the role confusion and blurring between registered nurses and assistants.

2.3.4 Summary

A major feature of this section was the examination of the roles and responsibilities of HCAs, and the associated changes that have occurred in recent years to the role. It is proposed that there is a blurring of boundaries between the role of the HCAs and that of registered nurses.

Moreover, given that there is no recognised regulatory framework for HCAs in Ireland and no regulatory requirement to follow standardised programmes of education this has led to variations in the utilisation of the role, resulting in a plethora of titles that contributes further to the confusion and role ambiguity for all concerned.

The literature claims that the HCAs are being increasingly used as substitutes for nurses and, thereby encroaching on the roles of these registered professionals. The consequences of these substitution strategies is that these lower status occupations are involved in non-

supervised direct patient care, performing duties beyond their level of competencies and consequently infiltrating what was previously acknowledged as the registered nurses' occupational domain; all of which raises serious quality and safety questions (Mckenna et al., 2004; Griffiths and Robinson, 2010).

Some of these themes will be revisited in the section to follow which will examine the relevant literature associated with the relationship between HCAs and other healthcare professionals with a particular emphasis on registered nurses.

2.4 Relationships with other professional staff

The following section highlights the varying perspectives associated with the HCA role and explores the relationship between HCAs and other healthcare professionals with a particular emphasis on registered nurses. This closeness to the registered nurse is significant in the delineation of the HCA role. This section will also illuminate the importance of power in relationships for the control and differentiation of nursing work between the two groups. Moreover, at the heart of these relationships is the notion of accountability as a reference point for guiding performance and assuring patient and public safety. Consequently, a key feature of this section of the review will be the influence of supervision and delegation on the interface between HCAs and nurses. It will be argued that the absence of regulation for HCAs generates additional confusion and concerns in the workplace.

A collaborative working relationship between HCAs and registered nurses is highly reliant on the reciprocal acceptance and support of both groups. However, the employment of HCAs has been and continues to be a controversial issue that has stimulated much discussion as outlined in previous sections of the literature review. Commentators have suggested that the division and restructuring of nursing is often met with cynicism and resistance by registered staff (Keeney et al., 2005). Many nurses view the employment of HCAs as a cheap replacement for registered staff and lament the loss of the essence of their role with the unintentional consequence of creating tension between the two groups (Thornley, 2000; Alcorn and Topping, 2009).

Other commentators point to the HCA role as an example for the model of subordination (see for example Saks and Allsop, 2007). Subordination is a product of the division of labour whereby subordinate groups are created below dominant professions, which is a

great advantage to the profession in terms of delegating routine work (Abbott, 1998; Hughes, 1984).

The studies considered in this section examine various perspectives, illuminating areas of agreement and areas of tensions in the HCAs' role. Whilst HCAs may view role development positively, registered nurses may perceive this as a threat to their own role. It is important to present the varying perspectives to better understand the influences on the working relationships between both occupational groups.

Daykin and Clarke (2000) undertook a small scale qualitative study to determine the impact of nursing skill-mix in two wards providing care to elderly patients in an English NHS Trust. The researchers report a sense of ambivalence towards HCAs on the part of the registered nurses. This ambivalence is explained by a broad welcome for the HCA role on the one hand which is perceived to enhance the professional status of nursing but on the other hand is viewed as a threat to the essence and uniqueness of the nurses' role (Daykin and Clarke, 2000).

The findings reveal tensions between nurses and HCAs based on perceptions that skill mix undermines the holistic model of care, much valued by nurses. However, HCAs view skill mix as an opportunity to develop knowledge, skills and ultimately greater job satisfaction (Daykin and Clarke, 2000). The study also suggests that the supervision and mentoring of HCAs by registered nurses was perceived to be of low priority by nurses. The authors conclude that nurses may need to reconsider their relationships with HCAs in the interest of inclusivity and valuing care work (ibid). It could be argued that the findings from this small-scale, localised study are reflective of the local culture and may be difficult to generalise to a broader population.

Spilsbury and Meyer (2004) report on a case study that examined the relationship of HCAs and registered nursing staff in one English acute hospital. The interactions between the HCAs and nursing staff are conceptualised under the headings of the *use*, *misuse* and *non-use* of HCAs. The researchers reported varying experiences in the utilisation of the HCA resource. These experiences included on the one hand the non-use of HCA skills as a consequence of registered nurses preventing HCAs from putting their skills and experience into practice and on the other hand the misuse and exploitation of the HCA role whereby assistant staff were used in ways that were beyond the expectations of their training and

competence. Whilst, this study was conducted in just one hospital and is therefore limited in terms of generalisability, it provides some in-depth insight into factors influencing HCA activities.

There have been a considerable number of research reports following implementation of the national HCA training programme in the Republic of Ireland. One such report by Keeney et al. (2005) reveals the attitudes of healthcare managers in Ireland to the national training course and their willingness to employ HCAs who had completed the course. In their study, most of the respondents (n=70) affirmed that they would employ HCAs on successful completion of the programme. In terms of the position of the HCA, most managers saw it as supporting nurses, however, the findings also reflect issues associated with the introduction of this role such as encroaching on the territory of registered staff. The authors caution that this encroachment has the potential to contribute to role confusion, role strain and role conflict. There is also a warning that the introduction of HCAs has been met with scepticism by a number of qualified staff who regard them as a cheaper alternative. Whilst the findings from this study are eleven years old, they still have relevance to my research. However, in critiquing this study it is important to note that the questionnaire was not piloted increasing the risk of written questions being ambiguous or misunderstood (Polit and Beck 2013).

Many of these perceptions and relationship challenges were echoed in a large multi-method case study undertaken by Kessler et al. (2010). Of interest to this study are the findings associated with the consequences of the HCA role for HCAs themselves and registered nurses. In exploring outcomes for the HCAs themselves, the picture to emerge suggests that concerns, raised by HCAs about their working lives, often related to relations with registered nurses and other professions (Kessler et al, 2010). Through observations of practice the authors noted that at handover meetings '*HCAs were rarely seen as making an input into handover; moreover there were occasional signs that HCAs were intimated in making an input into ward meetings involving professionals*' (ibid: 94). In addition, the sense of degradation and feelings of being undervalued on the part of the HCA were reflected in perceptions of being 'dirty workers', 'dogsbodies' and 'workhorses'.

Moreover, whilst there was a strong consensus amongst nurses in all participating sites that HCAs added value to their working lives and the relationship with HCAs was not problematic, some tensions and concerns were unearthed relating to 'them and us'

divisions between nurses and HCAs. These included misconceptions of the nurse role on the part of the HCA and the consequences of delegation and accountability both on the part of the HCA and the registered nurse. The findings in this study are consistent with the most recent survey of healthcare support workers undertaken by the UNISON trade union in the UK. UNISON surveyed nearly 2,300 healthcare support workers from across the UK working in a range of healthcare settings from primary care to emergency care, and community care to hospitals. In the survey, HCAs reported that they are ‘...*undervalued, increasingly overworked, and struggling to get the supervision they need. Low pay and lack of career progression mean they are struggling to make ends meet, when many could earn more stacking supermarket shelves than they can caring for patients*’ (UNISON, 2016: 3).

In a further affirmation of the variability in the relationships between HCAs and registered professionals, Munn et al. (2013) illuminated the different types of relationships between health assistants and professionals. These relationships can be tense or stressed, or may be functional and effective (Munn et al. 2013). The synthesised data also points to barriers that exist to the successful integration of HCAs into teams that include lack of clarity regarding assistant roles and negative perceptions of assistants by health professionals.

The findings from these studies illustrate some of the issues related to relationships between assistants and professional healthcare staff, whilst endeavouring to support the HCA function.

2.4.1 Supervision, Delegation and Accountability

Supervision, delegation and accountability remain central issues within the topic of regulation of HCAs in Ireland. Evidence points to increasing concerns over lack of appropriate supervision and delegation (Kalisch et al., 2009; Shannon, 2012; Cavendish, 2013; McLoughlin, 2014) as well as ambiguity surrounding accountability for HCAs’ interventions (Centre for Allied Health Evidence, 2006; Fealy et al., 2014).

Supervision may be direct and indirect. Direct supervision means that the supervising nurse is actually present and works alongside an unregulated HCA undertaking a delegated role or activity. Indirect supervision implies that the nurse does not directly observe the unregulated HCA undertaking a delegated role or activity.

Closely associated with supervision are issues of delegation and accountability. Mueller and Vogelsmeier (2013: 24) define delegation as the transfer of authority by a nurse (the delegator), who is responsible for health care delivery, to another person to perform a particular role or activity that is normally within the scope of practice of the delegator. Meanwhile, the Nursing and Midwifery Board of Ireland (2015: 17) describe accountability as the cornerstone of a professional and '*...being answerable for the decisions made in the course of one's professional practice*'. Consequently, in the course of his/her professional practice, a practitioner must be prepared to make explicit the rationale for decisions they make and to justify such decisions in the context of legislation, professional standards and guidelines, evidence based practice and professional and ethical conduct (ibid).

In its most recent 2014 edition of the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives, the Nursing and Midwifery Board of Ireland (NMBI) is unambiguous in declaring that nurses are accountable if they make a decision to delegate a nursing task to someone who is not a registered nurse. More recently however in 2016, the Irish Nurses and Midwives Organisation (INMO) called on the NMBI regulatory Board to further clarify the responsibility of the delegator and the specified accountability of the HCA in delivering care; such is the level of concern that still exists among its members. In support of the position taken by the INMO, the literature provides evidence that point to a lack of clarity on the part of the registered nurse and the HCA regarding accountability for delegated tasks (Oldfield, 2009; Moran et al., 2011).

The British Association of Critical Care Nurses (2003) undertook a survey in an attempt to clarify issues relating to supervision, delegation and accountability in their position statement. This involved the circulation of questionnaires to 645 senior nurses of critical care units in UK with a 58% response rate. The survey covered themes relating to assistant staff including numbers employed, job titles, training, direct and indirect tasks. This analysis acknowledges that there is reluctance among nursing staff to delegate core nursing tasks to HCAs. It also points to concerns regarding competency of HCA staff to undertake the tasks, accountability for tasks delegated and the absence of regulation for assistant staff with the consequence that they are not professionally accountable. However, the authors emphasise that if the three components of knowledge, ability and authority are present then the HCA is accountable for the delegated task and the '*...registered nurse's responsibility*

rests upon the notion that the task has been appropriately delegated' (British Association of Critical Care Nurses, 2003: 8).

There is a note of caution, however, that the delegation of tasks to HCAs needs to be made explicit through relevant education and competency based training, thereby protecting the public and by extension the delegating nurse and employing healthcare organisation (British Association of Critical Care Nurses, 2003: 9). Whilst this has some utility in clarifying aspects of accountability and delegation, it was disappointing that the survey excluded the participation of HCAs.

Meanwhile, Shannon (2012) in his thesis found evidence that the process of delegation from nurse to HCA was confusing and compounded by the indistinguishable roles and responsibilities of both registered nurses and HCAs in acute hospitals in Ireland. Furthermore, this study found a diversity of views from participants in relation to what exact tasks could be delegated to HCAs from nursing staff that only adds to the challenges inherent in clarifying roles. The author concludes by declaring that the competence of HCAs in Ireland needs to be reassessed, together with ongoing monitoring and supervision of their work to enhance their contribution to care and ultimately quality outcomes (Shannon, 2012).

Bosley and Dale's (2008) exploration of the perceptions of HCAs' role suggested that the key to promoting patient safety is to ensure that HCAs are trained and competent to undertake the tasks delegated to them, and that accountability is clear. In concurrence with Shannon, the authors of this study identify the need for HCAs to possess the necessary knowledge, skills, and competence to undertake delegated tasks. However, this study cites evidence that nurses are reluctant to delegate specific tasks to HCAs, which the authors observe may be *'a consequence of a sense of threat to the dilution of valued skills on the part of the nurse, concerns about accountability or an attempt to protect professional identity'* (ibid: 122). The authors also observe that regulation should clarify the situation by standardising training and introducing professional accountability for HCAs.

As mentioned previously, there have been a considerable number of research reports following implementation of a national HCA training programme in the Republic of Ireland. Keeney et al. (2005) reported on a hospital-focused part of a larger study evaluating the introduction of the national HCA training programme. The researchers

employed a survey methodology to explore how nurses, midwives and clients viewed trained HCAs. The study revealed that the employment of HCAs yielded positive outcomes for registered nurses and patients. However, additional workload and responsibilities for nurses associated with the training and supervision of HCAs was also highlighted (ibid). This finding has been echoed in earlier studies (see Harper, 1986 and Chang and Lam, 1998). Keeney et al (2005) also suggest that the additional supervisory responsibilities have altered the dynamics of the nurses' work who are now less available to provide direct care duties. This study was limited in terms of its sample size and restricted to one hospital, which is acknowledged by the authors.

In a more recent study, Alcorn and Topping (2009) specifically addressed the question of registered nurses' attitudes toward healthcare assistants with an emphasis on the themes of delegation and accountability. They employed a survey method that received responses from 148 registered nurses working in an English NHS trust. The findings revealed that the majority of the respondents (61%, n=91) were in favour of registration for HCAs with a professional statutory regulatory body. The study also found that most registered nurses indicated that they delegated tasks to HCAs and remained professionally accountable for the action of those HCAs (Alcorn and Topping, 2009). Nevertheless, more than half of the respondents agreed that HCAs should be held accountable for their actions if adequately prepared (ibid). The authors conclude that the role of registered nurses in developing HCAs has implications for their own training needs in ensuring that they are adequately equipped to supervise and delegate work to HCAs.

Whilst the findings of the study have utility, the methodology employed was one-dimensional and only the views of RNs were sought. In the most recent attempt to give a coherent explanation to the issues raised by nurses, HCAs and previous commentators in respect of supervision, delegation and accountability, Fealy et al. (2014) undertook a national review of the Scope of Nursing and Midwifery Practice on behalf of the Nursing and Midwifery Board of Ireland. Scope of practice is a terminology used in the regulation of various professions. It defines the procedures, actions and processes that are permitted for the individual who is registered or licenced to practice. The individual practitioner's scope of practice is determined by the professional's education and competence, which, in turn, give authority to perform a particular role or task (ibid: 52).

Fealy et al (2014) in reviewing the literature for this report identified a number of interesting findings from research that had been conducted in relation to the aforementioned themes. These include an Australian qualitative study that reported that nurses equated good nursing to working in proximity to patients providing total patient care (Schluter et al., 2011). However, the authors warned that this ability to practice in proximity to patients could be restricted by factors such as increasing reliance on healthcare support workers to provide direct patient care and perceived difficulties on the part of nurses in interpreting core nursing roles which could not be delegated (ibid: 8). This would suggest ambiguity regarding what constitutes core nursing roles and functions and associated decisions regarding the delegation of roles and tasks to HCAs.

A significant finding from the study was the correlation between age and the frequency with which nurse respondents reported recognising their own accountability for a decision to delegate tasks. Respondents in the older age category were significantly less likely to consult a line manager and to recognise their own accountability more when making a decision to delegate when compared to their younger counterparts (Schluter et al., 2011).

Fealy et al (2014), meanwhile, point to significant ambiguity over the supervisory roles and accountability for work performed by HCAs in Ireland. In terms of accountability, the authors suggest that qualified staff are fearful to pass on roles to HCAs, as they are unsure of where the accountability lies if something were to go wrong. This lack of 'trust' is perceived to be harmful for professional relationships between registered professionals and support workers.

Moreover, identical issues were identified shortly after the introduction of the HCA programme in Ireland which led to the publication of the 'Report of the High Level Group on Health Care Assistants Regarding the Implementation of the Health Care Assistants' Programme'. This report recommended that registered nurses:

...receive training to understand the principles of FETAC (formerly NCVA) assessment; appreciate the role of the health care assistant as related to FETAC criteria; and increase the qualified nurses' knowledge and awareness of accountability in relation to delegation and supervision of health care assistants prior to the implementation of any programme. (HSE, 2006: 7)

Consequently, an educational awareness programme for nursing staff on the FETAC level 5 programme and health care assistants was developed and implemented nationally. It is therefore disappointing that despite this investment in training nurses remain unclear about their level of responsibility and accountability when supervising and delegating tasks to HCAs (Fealy et al., 2014).

Finally, a most recent study in the USA acknowledges that registered nurses may not be fully aware of the competencies of the nursing support staff and therefore may be uncertain of what they can legally delegate to assistants (McMullen et al, 2015). Consequently, some nurses may not delegate duties appropriately in accordance with the qualifications and competencies of the relevant nursing support staff.

2.4.2 Summary

Research examining perceptions of HCAs' work and their relationships with nurses has taken into consideration the perspectives of HCAs, registered staff and managers. However, these perceptions present a complex picture of HCAs' work and highlight considerable overlap between the work of registered and non-registered nurses. This overlap is described in studies of nurses' perceptions as a 'threat' to the nurses' role. However, HCAs view these overlaps as an opportunity for role development. Whilst the literature does acknowledge the positives in the relationship between both groups, there remain underlying tensions and concerns relating to lack of role clarity, role erosion, role degradation and general lack of recognition and respect.

Furthermore, delegation and accountability for HCAs has been identified in the literature and remains central within the discussion of regulation for HCAs. In fact numerous literature evidence points to increasing concerns over lack of appropriate supervision and delegation as well as ambiguity surrounding accountability for HCAs' interventions. There is general consensus in the literature that lack of supervision of unregulated HCAs together with inappropriate delegation and confused accountability present an ongoing risk to the public. The next section of the literature review will explore in more depth the impact of the unregulated HCA role on quality and patient safety.

2.5 Patient Safety and Public Protection

A motivation for this research was the emergence of global concerns raised over patient safety, public protection, quality of care and the misuse of healthcare assistant employees. Therefore, as a follow on from the previous discussion on the nature of the working relationship between HCAs and registered nurses, this section will consider the literature associated with the impact of the role of the HCA on patient safety and public protection.

Patient safety and public protection has been at the heart of policy makers' concerns in Ireland, especially in recent years by an increased number of legal cases, associated liabilities and an apparent dropping in public trust in healthcare providers (Lourdes Hospital Inquiry, 2006; HIQA Tallaght Hospital Report, 2012a; Aras Attracta Swinford Review Group, 2016). The importance of this has been observed in recent reforms to professional regulation and inspection. The implementation of the Health and Social Care Professionals Act in 2005 and the Nurses and Midwives Act in 2011, as well as the establishment of the Health Information and Quality Authority in 2007 are evidence of a shift towards greater regulation.

In recent times, due to the increasing focus on the quality of health care provided and the move towards compassionate patient-centred care, questions have been raised on several issues associated with HCAs. These include a common definition and understanding of the HCA role, duties and responsibilities, the requisite training and competencies of HCAs and potential evidence for effectiveness of interventions provided by support workers in health care (Centre for Allied Health Evidence, 2006).

The literature would suggest that HCAs are generally valued by their colleagues (Carr-Hill et al., 2003); however, there is a dearth of strong empirical evidence in support of the extent and nature of the contribution that HCAs make to the delivery and outcomes of care (Centre for Allied Health Evidence, 2006; Bosley and Dale, 2008; Berta, 2013). This can be partly attributed to the generic nature of the role of the HCA that is embedded in multidisciplinary teams and extends throughout the continuum of care. Consequently, as Buchan and Dal Poz (2002) have explained, determination of specific outcomes as a result of specific interventions provided by support workers can be difficult to capture and measure.

In practice the majority of HCA work activity comes under the heading of direct care whilst registered nurses have tended to move away from direct bedside care to other activities such as paperwork and discharge planning (Gillen and Graffin, 2010; Cavendish, 2013; Munn et al., 2013; Johnson et al., 2015). These patterns of use of HCAs were perceived, by both registered nurses and HCAs, as having implications for patient care, safety, and overall nursing teamwork (Spilsbury and Meyers, 2004).

This position was supported by McKenna et al. (2004: 455) who voiced concerns about the use of HCAs, asserting that '*the increasing reliance on HCAs raises serious quality and safety questions*'. In one of their stronger arguments for regulation of HCAs in the public interest the same authors cite incidents whereby HCAs were dismissed from their work, yet commenced employment in another similar setting shortly afterwards. They further argue for the removal of another loophole whereby, at present, a nurse or other healthcare practitioner who is removed from their professional register can return to clinical practice as a frontline healthcare assistant, presenting a risk to patient safety and the public at large (ibid). Such an incident occurred in 1986 whereby a convicted rapist was removed from the nursing register in the UK and subsequently was employed elsewhere as a healthcare assistant working with vulnerable individuals with mental illness (Duffin, 2006).

Concurring with these identified risks, Griffiths and Robinson (2010) undertook a scoping review of the role of the unregulated HCA in the UK. The review indicated that an unregulated HCA workforce might present risks to public safety due to:

- ♦ Lack of controlled admission to the workforce through a centralised register;
- ♦ Provision of care by a workforce that may or may not have the requisite training and competencies to underpin practice;
- ♦ Provision of care that is inconsistently supervised by registered nurses (ibid: 31).

However, the report did not unequivocally state that unregulated support workers present a risk to public safety, instead it was noted that this was likely but not an absolute certainty (Griffiths and Robinson: 31).

More significant research studies that attribute improved clinical patient outcomes to the changes in mix and quality of nursing teams originally emerged in the literature, most notably in the USA. According to Kessler et al. (2010: 32) these studies '*raise some questions about the impact on the quality of care as more HCAs are used relative to nurses*'. Aiken et al. (2002), for example, reported a positive relationship between patient-to-nurse ratios and risk-adjusted mortality rates. Meanwhile, similar findings were also being reported by Needham et al. (2002) in the USA emanating from a large scale study covering 799 hospitals across eleven states. They identified that quality of care was positively influenced by an increase in direct nursing care hours. Both studies imply that substituting HCAs with nurses will enhance clinical patient outcomes and, thus, the inverse will also apply.

However, research studies attributing improved clinical outcomes to changes in staffing skill mix are not without their critics. Jenkins-Clarke and Carr-Hill (2003) claimed that the relationship between the cost of nursing care provision and quality outcomes was inconclusive as a consequence of attempts to determine quality of care using clinical risk data.

Nevertheless, these research studies that could potentially guide policies and practices on safe hospital nurse staffing continue to have traction in the USA and more recently in Europe. Rafferty et al. (2007) examined the effects of hospital-wide nurse staffing levels (patient-to-nurse ratios) on patient mortality, failure to rescue (mortality risk for patients with complicated stays) and nurse job dissatisfaction, burnout and nurse-rated quality of care in English acute hospital trusts. This large-scale national study supports US findings that a strong association exists between nurse staffing and mortality and also showed that job dissatisfaction and burnout were associated with low staffing levels. The authors also hold that the evidence posited supports the concept that the positive relationship between low nurse: patient staffing ratios and favourable patient and nurse outcomes is now an international phenomenon (Rafferty et al., 2007).

The most significant European study to date was undertaken by Aiken et al. and published in 2014. The RN4CAST research project which was funded by the European Commission was designed '*to assess whether differences in patient to nurse ratios and nurses' educational qualifications in nine of the 12 RN4CAST countries with similar patient discharge data were associated with variation in hospital mortality after common surgical*

procedures' (Aiken et al., 2014: 1). This pan-European observational study obtained discharge data for 422,730 patients aged 50 years or older who underwent common surgeries in 300 hospitals in nine European countries including Ireland. The authors concluded that a variation in hospital mortality is associated with differences in nurse staffing levels and educational qualifications. Therefore it can be demonstrated that an increase in nurses' workload increases the likelihood of in-patient hospital deaths, and an increase in nurses with a bachelor's degree is associated with a decrease in in-patient hospital deaths (ibid: 4). If one therefore accepts these findings, it also implies that there is an association between increasing the number of less qualified unregulated healthcare assistants (and reducing the overall mix of nursing skills) and higher mortality rates in acute hospitals in Ireland.

The data collated and analysed to inform these findings relates to the years 2007 – 2010 which corresponded with the onset of the economic collapse in Ireland and the rest of Europe. These timelines therefore do not reflect the situation in our healthcare services with the subsequent effect of austerity measures introduced into several countries thereafter. It could be argued that the results could be very different if the study was replicated in the aftermath of austerity measures in Ireland. These resulted in a '*reduction of 12,500 staff from the peak of employment in the health service in 2007*' (HSE, 2014a: 5). This research does represent a significant development that could potentially inform policies and practices on safe registered and non-registered nursing staffing levels in hospitals across Europe.

Meanwhile, new research from Australia warns that hospitals should '*exercise caution*' when using nursing assistants to work alongside registered nurses because the impact on care '*may not be positive*' (Twigg et al., 2016: 199). The aim of this large scale study was to measure, using administrative health data, the impact of adding HCAs to acute care hospital ward nurse staffing on adverse patient outcomes. There is currently a dearth of research examining the relationship between adverse patient outcomes and the introduction of unregulated HCAs to support existing staffing in an additive model (Duffield et al, 2014) which adds to the significance of this study. The research was undertaken between 2007 and 2010 using 256,302 patient records across eleven acute hospitals. The authors found a significant positive correlation between the extra time patients spent on wards staffed with additional HCAs and the likelihood of developing urinary tract infections (UTIs) and pneumonia. Furthermore, there were also notable increases in pressure injuries,

falls and sepsis in wards with additional HCAs compared to the non HCA wards. Perhaps the most striking conclusion to emerge from the data is that, logically, adding HCAs (additional resources) to existing ward staffing should decrease adverse patient outcomes, but contrary to expectations this study suggests that patients have increased odds of developing adverse outcomes when spending time on wards with additional HCAs (Twigg et al., 2016). However, the authors caution that due to limitations in the study design it is not possible to determine a causal pathway.

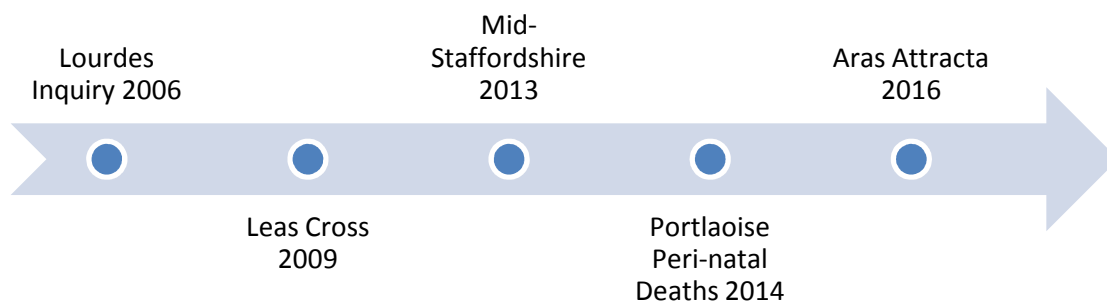
Despite the concerns raised in the aforementioned studies there is a widely-held view that nurses welcome the employment of HCAs (McKenna and Hasson, 2002; Duckett et al., 2013; Jenkins and Joyner, 2013). In a study undertaken in 2005 following the introduction of the trained HCA to the Irish health service the authors noted that there was a high level of satisfaction among staff and client respondents with the standards of work and levels of expertise demonstrated by this occupational group (Keeney et al., 2005). The authors also observed that this strong show of support from other staff groups would be instrumental in the successful integration and acceptance of the trained HCA into the clinical teams. Other studies have noted that HCAs were perceived as more approachable by the patient and frequently described as the backbone of the services (see for example Spilsbury et al., 2013).

2.5.1 Recent Inquiries and Investigations into deficits in standards of patient care and public safety

However, over recent years, a significant number of inquiries both in Ireland and the UK have illuminated the deficits in standards of patient care and patient safety. Many of these inquiries have raised important themes in terms of shaping the future of professional regulation, protection of the public and an increasing distrust of healthcare professionals and related occupational groups. As a consequence of the appalling facts that emerged from these inquiries, the public has developed an unprecedented scepticism towards health services in Ireland and the UK (Health and Social Care Regulatory Forum, 2009). Inquiries of various formats are established to investigate matters of significant public concern. The purpose of inquiries is summarised succinctly by the Law Reform Commission (2005) into six categories; to establish the facts; to learn from events; to provide catharsis or therapeutic exposure; to offer reassurance; to establish accountability, blame, and retribution; and for political purposes.

A list of reports and investigations following adverse clinical events in Ireland between 2002 and 2016 is presented in Appendix 1 of this thesis. A relevant sample of these inquiries will now be examined in the context of this study. See Figure 2-1 below with the relevant timelines.

Figure 2-1 Relevant investigations and inquiries



The Lourdes Hospital Inquiry Ireland (2006) exposed the practices of Dr. Michael Neary, an obstetrician who had the alarming propensity to remove the wombs of mothers in childbirth that made him a risk to women in this hospital. The report identified that Dr. Neary carried out 129 out of a total of 188 peripartum hysterectomies between 1974 and 1998, when most obstetricians would carry out less than ten in their whole career (Harding Clark, 2006: 30).

In her final report Judge Harding Clark stated that appropriate action must be taken in order to protect the public, '*Clinical independence should no longer be interpreted as a license for arrogance, disregard for patient choice, dignity and need or freedom from accountability*' (Harding Clark, 2006: 54). Her recommendations paved the way for the introduction of clinical governance structures, national audit and reporting systems and appropriate procedures for dealing with complaints regarding clinical practice in Ireland (ibid: 323).

More recently the Commission of Investigation in Ireland published a report in relation to serious deficiencies in the treatment of residents at Leas Cross, private nursing home, Dublin. The investigation was undertaken following a documentary broadcast by R.T.E. television on the 30th May 2005, which '*provoked a strong public reaction*' (Commission of Investigation, 2009: 9). Within the report concerns were expressed regarding the utilisation of care attendants (HCAs) as substitutes for nurses and were not adequately

trained to provide complex care to residents (ibid: 98). The Commission revealed that only 30 of the 156 care attendants had evidence of training in health care (ibid: 101).

These cases reflected badly on healthcare professionals in Ireland and were subject to widespread criticism (Drennan et al., 2012). In the UK Robert Francis's report into the failings at the Mid Staffordshire Foundation Trust was published in February 2013 concerning poor care and high mortality rates among patients. The issues of patient safety and quality were in the public eye more than ever. The Inquiry provides stark evidence of examples of leaders, managers, regulators and others who failed to prioritise the interests and requirements of patients. The report proposed 290 recommendations of which six were directly targeted at healthcare assistants/support workers. A landmark recommendation was that:

...a registration system should be created under which no unregulated person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (Francis, 2013: 107)

In the wake of the above inquiry and other reports of failings in hospitals and care homes, a further review was commissioned by the Secretary of State for Health to examine what could be done to ensure that unregistered staff in the NHS and social care treat all patients and clients with care and compassion. Whilst recognising the important contribution of HCAs, the Cavendish Review made eighteen recommendations covering:

- ♦ Recruitment, Training and Education;
- ♦ Making Caring a Career;
- ♦ Getting the Best out of People: Leadership, Supervision and Support; and
- ♦ Time to Care (Cavendish, 2013: 9-10).

Missing from the review, however, was support for the professional regulation of healthcare assistants as recommended by Francis, 2013 a mere five months earlier. Instead Cavendish proposes that all healthcare assistants and social care support workers should

undergo the same basic training, based on the best practice that already exists in the system, and must get a standard '*certificate of fundamental care*' before they can care for people unsupervised. In addition, the review recommends a code of conduct and a clearly defined career pathway as a means to support appropriate delegation, clearly define roles and enhance staff retention (ibid: 9-10).

In Ireland a further investigation centred on the deaths of four babies in a six year period at the Midlands Regional Hospital Portlaoise. The subsequent report recognised that patients and families were treated in a poor – and at times – appalling manner, with limited respect, kindness, courtesy and consideration (Department of Health, 2014b: 10). The author of the report, Dr. Tony Holohan, acknowledges the breakdown in trust between healthcare professionals and service users arising from failure to communicate and acting defensively (ibid, 2014). Among the 42 recommendations arising from the review was a requirement for the Health Service Executive to undertake a comprehensive review of the potential role of maternity care assistants in Ireland, including training requirements and to identify the roles and responsibilities that could reasonably and safely be delegated by a registered midwife (ibid, 2014).

The most recent investigation in Ireland was the exposure by the RTE Prime Time Investigation Unit of abuse in Aras Attracta, a residential respite and day service facility for adults with an intellectual disability. Using undercover filming, the RTE programme broadcast on December 9th, 2014 made for disturbing viewing and showed evidence of force feeding, slapping, kicking, physical restraint and shouting at residents by both regulated and unregulated staff members (Health Service Executive, 2016).

The outcomes from all of the above inquiries and investigations into deficits in standards of patient care have resulted in widespread public condemnation of health services, healthcare professionals and regulatory authorities. Consequently, various commentators have called for regulated care for vulnerable patients (Francis, 2013; Scott, 2015).

2.5.2 Abuse

Further concerns regarding the HCA roles centre on the fact that evidence exists to suggest that incidents of abuse and neglect on the part of care staff are underreported (Cooper et al., 2009; Natan et al., 2010; Lafferty et al., 2012). Drennan et al. (2012: 16) revealed several possible reasons for non-reporting or underreporting of abuse including '*a lack of*

training or education in the recognition and reporting of abuse, too few staff to investigate abuse, a fear of reprisals from colleagues and employers and a lack of coordination amongst the various agencies charged with investigating abuse'. In an earlier study Harris and Benson (2000) reported that unregulated HCAs were the group of health care workers most likely to reveal that they had stolen from a patient in their care. The authors found that the extent of the unsupervised access HCAs had to patients and their personal belongings was a key contributory factor to the higher incidents of theft among this occupational group. However, little is known about the extent of sexual abuse by care staff on vulnerable patients due to the hidden nature of this form of abuse and the inability of some patients to report the abuse. One study in the US employed a retrospective analysis of reports of physical and sexual abuse in healthcare and found that HCAs were more likely to perpetrate sexual abuse than any other group of healthcare workers (Payne, 2010). A more recent study undertaken by Drennan et al. (2012) in Ireland contradicts the above findings and found no evidence to support these claims that HCAs are more likely to abuse or neglect patients.

Nevertheless, in response to these concerns, the HSE introduced a safeguarding policy for vulnerable adults who may be at risk of abuse. The policy places unambiguous responsibility on all service providers to ensure that all service users are treated with respect and dignity in an environment that promotes welfare and prevents abuse (HSE, 2014b). This includes ensuring '*...that there are procedures in place for the effective recruitment, vetting, induction, management, support, supervision and training of all staff and volunteers that provide services to, or have direct contact with, vulnerable persons*' (HSE, 2014b: 15).

2.5.3 Summary

This section examined the literature relating to the impact of the unregulated healthcare assistant on patient safety and public protection. A number of commentators have highlighted the value of the HCA role in contributing to enhanced patient outcomes. However, recent studies of skill mix in nursing teams challenge this view in suggesting that poorer patient outcomes are associated with higher proportions of assistant staff as part of the overall nursing team mix. Moreover, the literature also cites incidents of unregulated HCAs gaining employment with a health service provider after being dismissed from a similar post elsewhere for poor performance. The unregulated roles also attract

professional care staff that were removed from the register by their professional body and now present a potential risk to the public.

This section also examined a sample of reports arising from inquiries into deficits in care standards both in Ireland and the UK. These inquiries raised important themes in terms of shaping the future of professional regulation, protection of the public and highlighted the increasing distrust of healthcare professionals and related occupational groups including healthcare assistants.

Finally, very little was found in the literature on the question of abuse of vulnerable patients on the part of HCA staff. Whilst some international studies have found evidence of incidents of financial, physical and sexual abuse attributed to HCAs, the findings of a more recent Irish study do not support this earlier research (Drennan et al., 2012).

2.6 Conclusion

This chapter surveyed the ongoing evolution of the role of the healthcare assistant and addressed matters of role boundaries and role substitutions. What emerges is a complex picture and evidence that little clarity or consistency exists in terms of role function. The chapter also examined the literature in respect of the nature of the relationships between the HCA and other professionals and the impact of the role on patient safety and public protection. Some of these points will be revisited in Chapter three whereby the relevant literature associated with professional regulation and the theoretical framework will be examined in more detail.

Chapter 3 Literature Review – Public Interest, Public Choice and Professional Regulation

3.1 Introduction

This thesis is concerned with understanding the requirement and extent of professional regulation for healthcare assistants in Ireland and in particular focuses on the concept of public protection. In developing this understanding, the previous chapter explored the evolving role of the healthcare assistant, relationships with other professionals, and consequences for patient safety and public protection. This chapter will now focus on the current discourse associated with regulation of HCAs. The theoretical literature on the interests served by regulation will be considered and will introduce the theoretical concepts that are central to provide a framework for critique and analysis which will be drawn on throughout this thesis. Moreover, these theories provide a lens to view and make sense of the occupation of HCAs and further provide a solid foundation for the collection and analysis of empirical data to come. The second part of the chapter will focus on a growing body of literature associated with professional regulation of healthcare assistants. As a starting point, two alternative theoretical perspectives will be briefly considered before introducing the selected theories of public interest and public choice for this thesis.

3.2 Theoretical Perspectives

A theoretical perspective provides parameters for the study, guides data collection and data interpretation whilst also offering explanations or predictions of events (McKenna, 1997; Moody, 1990). In considering an appropriate theoretical framework, I was initially drawn to the work of Abbott (1988) and how his theory can be used to illuminate the evolving role of HCAs and subsequent requirement for professional regulation. Central to Abbott's thesis is the concept of '*jurisdiction*'. This is the control a profession exercises over a specific area of work to the extent that other occupational groups or professions are excluded. Competing for jurisdiction and interprofessional rivalry is viewed as a hallmark of professional life. In addition, Abbott (1988) also argued that professional knowledge is important and enables a profession to defend its position and claim further jurisdiction. Whilst jurisdictional boundaries may be formalised for professionals through job descriptions, Abbott suggests that jurisdictional boundaries may become vague and even disappear as other occupational groups and professions develop on-the-job knowledge of the professionals' role:

'Subordinate professionals, non-professionals, and members of related, equal professions learn on the job a craft version of a given profession's knowledge systems' (Abbott 1988:65-66).

The jurisdictional boundaries between HCAs and professional nurses have become increasingly blurred to the extent that both roles are becoming indistinguishable (The British Association of Critical Care Nurses, 2003; Bach, Kessler and Heron, 2008; Spilsbury et al, 2013).

Whilst Abbott's thesis offers insightful perspectives into jurisdictional and occupational boundaries, it does not explain the implications that unclear boundaries have on patient safety (Spilsbury, 2004) which is a significant focus of my study. Moreover, Abbott's approach is further criticised for its failure to adequately address the relationship between professionals and non professionals (Allen, 2001). The literature points to tensions between professional nursing staff and non-professional nurses (HCAs) due to the absence of regulation (Bosley and Dale, 2008 and Fealy et al, 2014). This theory was therefore considered for my study but abandoned as it did not offer sufficient explanatory value on the implications of professional regulation on patient safety and working relationships.

The second theoretical perspective considered was based on Weber's (1968) theory of social closure and later developed by Parkin (1979). According to Weber, the concept of social closure broadly refers to exclusion whereby access to resources and privileges are controlled by dominant groups. The argument posited is that dominant professions are composed of self-interested individuals who, in order to gain monopolies and privileges seek to exclude others from their group. Murphy (1988:8) further describes social closure as *'a process of subordination whereby one group monopolizes advantages by closing off opportunities to another group of outsiders beneath it which it defines as inferior and ineligible'*.

The argument adopted by Abel (1989:23) in respect of dominant professional groups is that *'closure can be achieved through exclusive rights to use a title, registration, or licensing'* thereby monopolising the market supply of labour. Parkin (1979) identified two main types of social closure; 'exclusion' and 'usurpation'. *'The distinguishing feature of exclusionary closure is the attempt by one group to secure for itself a privileged position at the expense of some other group through processes of subordination'* (Parkin, 1979:45).

Exclusion is associated with the exercise of power in a downward direction whilst usurpationary closure is the use of power upwards, by the groups of subordinates on higher privileged groups aimed at winning a greater share of the higher groups' power and benefits (Parkin, 1979). This theory has some relevance to my study as research suggests that unregulated HCAs attempt to usurp the dominant nursing profession for additional privileges and enhanced status, whilst registered nurses repel these attempts of usurpation through the employment of exclusionary tactics (Spilsbury and Meyers, 2004). These competing tactics between the dominant professional group and the subordinate group can have consequences for working relationships and role boundaries. Whilst social closure theory offers an explanatory understanding of the behaviour and tactics of dominant professional groups and the subsequent consequences for unregulated occupational groups, it does not adequately address the implications for practice of the unregulated group (HCAs) in the context of safety and risk. Social closure theory was not therefore considered appropriate for this study.

3.3 Economic Theories of Regulation

The theoretical underpinning to this study derives from two branches within economic regulations, those of public interest and public choice. The two competing theories have been offered to enable further understanding of real-world phenomena associated with an unregistered workforce (healthcare assistants), the implications this has for public safety and the consequential key drivers for professional regulation.

The public interest theory of regulation contends that regulation is introduced to benefit and protect the public by intervening to correct inefficient or inequitable market practices (Pigou, 1932). In other words it presumes public servants are impartial and altruistic and will implement regulation for the wider public good. Although Pigou's theory was developed to explain government interventions to correct inequitable market practices, the utility of his theory for this study lies in the concepts and their relationship to public interest.

This perspective though did not go unchallenged and an alternative theory of regulation, public choice theory, was proposed, as a differing approach to regulation. The main assumption here is that '*...regulation is supplied in response to the demands of interest groups struggling among themselves to maximise the incomes of their members*' (Posner, 1974: 335-336). An important feature of the public choice theory is that it abandons the

notion that regulation is an instrument to pursue public interest. Together, both theories offer an explanatory understanding of the possible drivers and motivations to regulate HCAs in the Irish health service.

3.3.1 Public Interest Theory of Regulation

A fundamental reason posited for regulation is for the protection of public interest and ultimately society itself (Deegan, 2005). But it is not always apparent what this means, and how healthcare professionals can determine whether they are meeting this expectation. A definition of public interest posited by the International Federation of Accountants (IFAC) is ‘... *the net benefits derived for, and procedural rigour employed on behalf of, all society in relation to any action, decision or policy*’ (IFAC, 2012: 1). Whilst this thesis will use the term public interest throughout, other terms such as public good, common good or public benefit are equally applicable.

Pigou (1938) conceptualises the public interest as a correction to market failures, such as natural monopolies, high transaction costs and information asymmetries through the intervention of an altruistic regulator. Proponents of public interest theory therefore maintain that the protection of the consumer is supreme and any regulatory intervention that achieves this can, by definition, be considered to be acting in the public interest (Baumol, 1956; Bonbright, 1961).

Many of the rationales for regulating can be described as instances of ‘*market failure*’ (Baldwin, Cave and Lodge, 2012: 15). According to Hertog, the public interest theories may be applied to ‘...*identify possible causes of market failures and to summarise possible regulatory solutions*’ (ibid, 2003:15). It may be argued, therefore, that regulation is justified if the unregulated healthcare workforce fails to produce the behaviours and outcomes in accordance with public interest (Baldwin et al., 2012). However, predictions from the public interest theory vary dependent upon the type of market failure (Olsen, 1999). Thus, it is paramount to initially identify the relevant market failure being addressed.

Healthcare services market failure is typically identified as occurring due to information asymmetries and three main issues have been identified. The first arises due to the differences in the levels of information possessed by healthcare service users (patients) and healthcare practitioners. As Arrow (1963: 951) states patients have less information than

physicians as to the '*consequences and possibilities of treatment*'. This leads Adams and Tower (1994) to point out that these consumers may not fully comprehend the importance and value of certain information leading to a breakdown in the autonomous functioning of this market. This is further compounded by difficulties experienced by some patients in determining the quality of the service available (Baldwin et al., 2012). Moreover, an inherent power imbalance develops within the relationship between the practitioner and the service user, which can increase the sense of vulnerability on the part of the consumer. This power imbalance in favour of the practitioner is a consequence of their access to private information about the person in their care (Nursing and Midwifery Board of Australia, 2010). Hence, public interest theory asserts that rigid and restricted entry requirements to healthcare professions through regulation corrects this market distortion by ensuring that healthcare professionals are of a sufficiently high standard to safeguard the public and reduce uncertainties in the mind of the patient (Arrow, 1963: 966).

In the absence of professional regulation and minimum quality standards in healthcare, Leffler (1978) warns that individuals may seek treatment and care from less competent practitioners increasing the risk to not only their own health and well-being but also society at large through the spread of disease and infection. This unintended impact on the broader population is referred to as an 'externality', whereby other people outside of the particular parties involved in an exchange or decision are affected (Baldwin et al., 2012). Thus, minimum standards are a requirement if members of the public fail to recognise the risks associated with receiving low quality healthcare services.

Secondly, issues may arise for the consumer where there is an increase in labour specialisation within the healthcare market and the ever-increasing divisions of roles resulting in role ambiguity. Patients and general public are often bewildered by the number and range of professionals and other occupational groups they encounter while receiving care as the services are often indistinguishable to the patient such as nurses, physiotherapists, healthcare assistants etc. Consumers may not have the required level of education or intellectual capacity to comprehend the available information in the correct way and thus will not engage in rational analysis (Garoupa, 2006). Regulation in this instance is justified if the regulatory body has more information and expertise available than the average consumer (ibid: 2006).

A third contributor to market failure is the propensity of consumers to evade their obligations to invest in information relating to their plan of treatment or care. Becker (1983) refers to this as ‘free riding’ whereby everyone shirks their obligations to attain the relevant information pertaining to the providers of the service and assumes that others have taken the responsibility but in fact no one actually has done the research. This is less prevalent in small interest groups such as patient representative organisations, but would be evident in large disparate communities.

In the absence of regulation, these market failures, particularly when information asymmetries are significant, will attract suppliers of lower quality services and thus drive out higher quality of services from the market posing a greater risk to the public (Baldwin et al., 2012). Hence, public interest proponents have argued that occupational groups may choose to self-regulate, or consumers may seek government regulation to ‘*eliminate charlatans, incompetents and frauds*’ to safeguard the public interest (Arrow, 1963; Leland, 1979). This regulatory intervention may therefore increase the wages of healthcare professionals, not because it limits competition at the expense of efficiency, but because it improves the quality of healthcare services that patients expect to receive.

Consequently, the predictive contribution of public interest theory holds that regulation is adopted to address problems of asymmetric information and hence improve the quality of service. The extent of this asymmetry in the distribution of information in healthcare will determine the value of the regulation. If there is no asymmetry, or it is unimportant because either the costs of obtaining information are low (e.g., little variation in service quality, little skill required to evaluate the service or if the benefit of having the information is low) then the value of regulation to consumers decreases with more restrictive regulation, since the range of price and quality choices available to consumers is being reduced (Graddy, 1991: 28).

Alternatively, if there is significant asymmetry in the distribution of information (as we expect in most health services), then the value of regulation depends on the ability of consumers to evaluate a service using available information. If consumers cannot evaluate service quality with existing information (because the service is complex or their knowledge inadequate), then the value of regulation to consumers increases with more restrictive regulation. If, however, consumers can evaluate service quality with appropriate

information, then a less restrictive or more proportionate regulatory response will have the highest value to consumers (ibid: 28).

3.3.2 Public Choice Theory

Public interest theory has been the subject of significant criticism in recent years not least from the proponents of public choice theory. Arguably, one of the most important works to dismiss the notion that regulators are benevolent and altruistic is Stigler's (1971) seminal work, 'The Theory of Economic Regulation'. Stigler's central proposition was that '*as a rule, regulation is acquired by an industry and is designed and operated primarily for its benefit*' (Stigler, 1971: 3). In other words he recognised that regulation has economic benefits and those individuals and groups seeking regulation are described as self-utility maximising agents. Posner (1975: 79) supports this notion when asserting that regulation acts to serve '*...the private interests of politically effective groups*' and hence generate significant income for them.

This view in maximising profits or income is achieved by the regulatory process being captured by the associated professional or occupational group to erect entry restrictions for their own benefit (Stigler, 1971). Regulation in this instance does not serve the public interest, but instead serves the interest of healthcare professionals by restricting supply and artificially raising incomes (Friedman, 1962). Moreover, public choice theorists suggest that those interest groups and professionals with measurable political clout over the government of the day can acquire the necessary regulation to restrict entry to their profession, limit competition and consequently increase wages (Friedman, 1962; Stigler, 1971; Olson, 2009; Baldwin et al., 2012).

This form of occupational monopoly, frequently referred to as social closure, refers to the profession's ability to restrict or close their occupation to 'outsiders' and thus maintain privileges and benefits for those who are members of the profession (Parkin, 1979).

Freidson (1974) describes the medical profession as the classic example of how occupations become professions and subsequently achieve social closure. He further asserts that medicine, relative to other health care professions, has attained true organized autonomy and power and is able to control the content of work and dominate non-professionals. Freidson further argues that the defining features of professions, compared

with unregulated occupations (such as healthcare assistants), are autonomy and self-regulation.

As seen in recent years this level of professional dominance and closure does not always protect the public interest as it can create a culture of secrecy surrounding adverse clinical incidents and medical malpractices as evidenced in the Bristol Royal infirmary inquiry (1998), and Lourdes Hospital Inquiry (2006). These scandals and others referred to in section 2.5.1 have led to a less passive and trusting society and the emergence of the articulate consumer demanding a more equal relationship with their health professionals. Thus, service users are no longer accepting the traditional role of the patient as a passive recipient of care (Health and Social Care Regulatory Forum, 2009).

Furthermore, service user involvement in regulation is paramount to promote openness and transparency, improve quality, encourage public accountability and counteract the risk of regulatory capture (Health and Social Care Regulatory Forum, 2009). It is not in the best interests of any profession to be unchallenged in its regulatory standard and processes, therefore, the Boards of the Irish Medical Council, the Nursing and Midwifery Board of Ireland and the Health and Social Care Professionals Council (CORU) are now all comprised of lay majorities.

Public choice theorists argue that occupational groups will pursue self-regulation in an attempt to protect themselves from competition and thus increase their incomes (Friedman, 1962; Peltzman, 1976; Stigler, 1971). In her analysis of six health occupations in 1991, Graddy noted that organised interest groups did influence how these groups were regulated. She also observed that all six occupations had strong professional associations to lead the effort for regulation (ibid: 31). This is reflected in the health professional landscape in Ireland whereby most professional groups have established their own associations and colleges to further enhance the status and profile of their occupational group and influence Government policy. In 2016 an association for healthcare assistants in Ireland was established to enhance standards of education, training and practice in the interest of patient safety. However, they remain a relatively large diffused group.

3.4 Summary

To recapitulate, this section has introduced public interest and public choice as the two theoretical concepts derived from economic regulations. This theoretical starting point will

help to explain the possible drivers and motivations to regulate HCAs in the Irish health service.

The public interest theory provides an explanation for the altruistic regulatory body or occupational group, which is considered to represent the interest of the society in which it operates rather than its own vested interests. It is directed at the correction of market imperfections such as information asymmetries in healthcare. The public choice theory on the other hand advances a different explanation. In its simplest form, public choice theory is a straightforward application of self-interest in the pursuance of maximising income and benefits for the occupational group being regulated. Both theories have been subjected to criticism, but in the context of this study, they offer together an explanatory understanding of:

- ♦ Information asymmetries associated with the role of the HCA,
- ♦ Power imbalance between HCA and service user as a consequence of information asymmetry,
- ♦ Ambiguous role boundaries between nurses and HCAs,
- ♦ The existence of inefficient or inequitable healthcare practices.

Finally, it is worth again noting that Graddy (1991) noted that healthcare occupational groups that successfully achieved professional regulation had strong professional associations to lead the effort for regulation. Healthcare assistants remain a large disparate group with the exception of representation through their trade union. The next section draws on some of these themes further as part of this literature review.

3.5 Professional Regulation in Healthcare

Having discussed the theoretical constructs underpinning this thesis, the final section of this chapter will focus on a growing body of literature associated with professional regulation in healthcare. As HCA roles are growing in many areas of healthcare and consequently take on more responsibility and autonomy in their roles then the issue of regulation that is the feature of this thesis comes into focus. The corpus of literature points

to growing calls for the statutory regulation of HCAs. This final section considers the nature and landscape of professional regulation in Ireland including influences on regulatory policy. Literature proposing alternative models of professional regulation appropriate for HCA occupational group will also be considered. Finally, I will examine the evidence underpinning the discourse on both sides of the regulatory debate regarding HCAs in the context of patient safety.

3.5.1 What is regulation?

This section begins by addressing the question of regulation and in particular the diverse set of instruments by which governments set requirements on enterprises and citizens. Selznick (1985: 363) defined regulation as '*sustained and focused control exercised by a public agency over activities which are valued by a community*'. Other commentators have generally accepted this definition (Walshe, 2003; Feintuck, 2004; Baldwin et al., 2012).

When applied to occupations, professional regulation is the process by which the practice of a job or specific function is monitored and controlled. In a healthcare context, professional regulation is intended to protect the public, making sure that those who practice in the healthcare profession meet required standards of education, competence and conduct (Griffiths and Robinson, 2010).

The UK Department of Health (2011:6) acknowledge public protection and the safeguarding of health service users as the key objective of regulation which can be achieved by:

- Setting standards of education and training for the professions that they regulate;
- Maintaining a register of those who demonstrate they meet these standards;
- Setting standards of conduct, ethics and competence required to remain on the register;
- Investigating concerns about professionals who are registered and taking appropriate action where individuals might present a risk to the public; and
- Taking action against those falsely claiming to be a registered professional.

A further feature of professional regulation is the protection of the title in law for those professionals who are statutorily regulated such as registered nurses. Therefore it is a criminal offence for those who are not registered practitioners to use such protected titles (Law Commission [UK], 2014).

In order to become registered and remain registered, healthcare professionals are required to meet and maintain the standards of education, conduct and practice that have been set by the relevant regulatory bodies. The regulators, in turn, have a responsibility to enforce these standards and apply sanctions to those practitioners whose practice falls short of the required minimum standard (Baldwin and Cave, 2012; Law Commission [UK], 2012).

Moreover, employers are responsible for checking that a person's registration allows them to be employed in a particular profession before they start work, and that they maintain appropriate registration to practice (HSE, 2015a). For their part, regulatory authorities have transparent systems to enable employers and the general public to check their registers for information indicating individual healthcare professionals who are qualified and fit to practice and any sanctions that have been imposed as a result of fitness to practise proceedings (Department of Health [UK], 2014). Professional registers are viewed as the “centrepiece of statutory regulation” and providing “a stamp of accreditation of the abilities, skills and qualifications of a professional” (Law Commission [UK], 2014: 55). Nevertheless, every profession has people who do not perform as they should and for the public to have confidence there must be a mechanism for the appropriate handling of these situations. We live in a society where trust and confidence in a profession is entirely dependent on accountability through regulation (Hanrahan, 2012). This accountability is made transparent and visible through public inquiries into conduct and/or competence of individual professionals, known as fitness to practice hearings ensuring that those who are deemed not competent will be appropriately sanctioned.

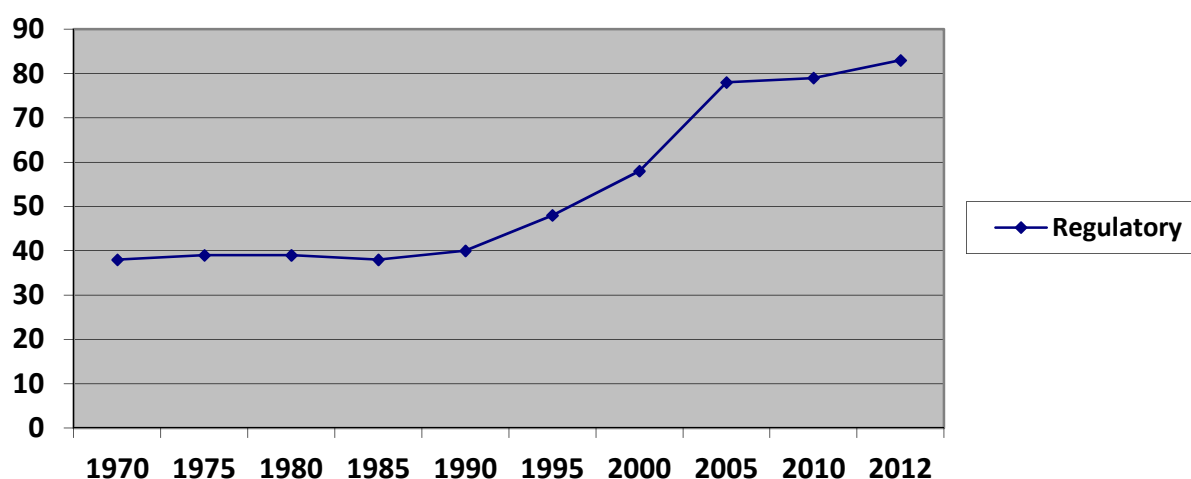
The existence of professional regulation together with professional registers is known to provide the public with a level of assurance that health care professionals will practice competently and safely (Fealy et al, 2009; Law Commission [UK], 2012). However, others point to diminishing public trust and confidence in the competence of professional regulators arising from previous healthcare scandals centred on regulated healthcare professionals in Ireland (Harding Clark, 2006; Madden, 2008; Bayne, 2012). Moreover, critics of regulation frequently point to the tardiness of its implementation that does not reflect or keep pace with changes in professional practice, technological developments or anticipate future needs (Professional Standards Authority, 2015). Effective and responsive regulation should therefore display features of agility whereby regulators are in a constant state of readiness to react to changes in professional healthcare practice (Professional Standards Authority, 2016).

In Ireland, regulated health and social care professionals are required to be registered with, and show that they meet the standards of, their respective regulatory bodies, in order to practice their profession. The regulatory authorities are the gatekeepers to regulated professions, and professional activities which require specific qualifications, and are subject to national law. The European Commission terms these organisations the ‘competent authorities’ (Braeseke, 2014).

3.6 Regulatory Landscape in Republic of Ireland

The growth of regulatory agencies has been an important trend in governance in Ireland and most OECD member states in the past thirty years (Scott, 2012). The number of active agencies for which regulation is the primary function has more than doubled in Ireland from forty in 1970 to eighty-three in 2012 (See Figure 3-1 below). The pace of growth has been particularly dramatic from 2000 onwards with a raft of new regulatory agencies established and imbued with statutory powers of investigation and enforcement (ibid).

Figure 3-1 Growth of regulatory agencies in Ireland 1970 - 2012



Adapted from Scott 2012

This pattern of growth in Ireland points to an increasing reliance on regulation, a phenomenon that is directly influenced by the country’s membership of the European Union since 1973 (ibid). However, commentators have questioned the number of regulators in Ireland and posit that regulation should be proportionate to the need and new regulatory bodies should not be created unless there was a compelling case for doing so (Purcell, 2008; Scott, 2012).

3.7 Regulation Policy

In an attempt to reduce the reliance on the full rigour of primary legislation and to allow a greater balance in regulatory policy making, the Government of Ireland published a white paper in 2004 committing to the six principles of Better Regulation (Government of Ireland, 2004). Central to this regulating framework is the principle of proportionality which emphasises a light touch to regulation including the consideration and use of alternative options. The other five principles are necessity; effectiveness; transparency; accountability and consistency. There is also an emphasis on balancing the costs of regulation with the overall benefits it confers.

This policy direction to adopting Better Regulation more recently renamed ‘Smart Regulation’ was congruent with political ideologies within the European Union (Brown and Scott, 2011). However, a recent report by EPS Consulting (2014: 3) noted that *‘the Better Regulation project, coordinated by the Government of Ireland, was disbanded in July 2011’*. As a consequence, the authors of the report argued that the government approach to Better Regulation has now been abandoned (ibid).

3.8 Influence of scandals on professional health care regulation policy in Ireland

Self regulation has prevailed as the dominant model of regulatory governance among health care professionals such as doctors, nurses and midwives in western countries. Self-regulation refers to *‘the control of activities by the private parties concerned without the direct involvement of public authorities’* (Department of the Taoiseach, 2009: 19).

Therefore, in respect of healthcare, self-regulation can be undertaken by health care professionals themselves by exerting controls over its own membership and their behaviours. Some commentators view self-regulation as the hallmark of status and professionalism (Abel, 1988; Grubb, 2004). However, critics point to the lack of trust that the public place on self-regulators who are not viewed *“as legitimate if they are seen to be able to circumvent external controls, or to be more strongly accountable to their members than to the public or those affected by their activities”* (Baldwin et al, 2014: 143). This view was confirmed by the findings from a number of high profile scandals involving healthcare professionals in the UK and Ireland that resulted in a dramatic evaporation of public trust in the accountability and transparency of self-regulation as a model of governance to oversee the practices and behaviours of healthcare professionals.

The revelations in relation to scandals such as the practices of Dr. Neary in the Lourdes Hospital (Harding-Clark, 2006) brought these failures and shortcomings of professional self-regulation sharply into focus and resulted in radical reforms to the regulatory frameworks governing healthcare professionals such as nurses and doctors (Kelly, 2009). As a consequence, the legislation governing the regulation of healthcare professionals in Ireland was amended in order to hold the relevant regulatory authorities more accountable to the public. Key among the reforms was the introduction of a majority lay membership or public interest representation on the professional healthcare regulatory boards such as the Medical Council (Government of Ireland, 2007) and the Irish Nursing and Midwifery Board (Government of Ireland, 2011). Furthermore, the changes in legislation provides for all fitness to practise inquiries to be held in public. It is argued that the revised composition of the regulatory boards together with the new fitness to practice process facilitates effective public participation, strengthens public trust and ensures decisions are transparent and made in the best interest of the public and not the profession (O'Connor, 2013). Included in the eighty-three agencies presented in Figure 3-1 above are six professional regulatory bodies that legally regulate twenty-seven health professions, consisting of approximately 120,267 professionals (see Table 3-1 below).

Table 3-1 Regulatory landscape of health and social care in Republic of Ireland

Professional Regulator	Year Established	Number of Professions	Number of registered Professionals
Nursing and Midwifery Board of Ireland (formally An Bord Altranais)	1950	2	64,790
Dental Council	1985	7	4,270
Health & Social Care Professionals Council (CORU)	2005	14	20,000
Medical Council of Ireland	1978	1	20,473 (Annual Report and Financial

			Statement, 2015, Medical Council of Ireland)
Pharmaceutical Society of Ireland (PSI)	2007	2	6,068
Pre-Hospital Emergency Care Council (PHECC)	2000	1	4,666

(Adapted from Health and Social Care Regulatory Forum, 2009)

Although differences exist between the various regulatory bodies in terms of their size and governance, their structures and functions are broadly similar, in that they all aim to protect the public from unsafe practitioners or poor-quality care. To fulfil these functions, and ensure the requisite level of protection, all have a similar suite of duties they are required to discharge. Included among these duties is the responsibility to set standards for education and training, maintain a Register of those who are appropriately qualified to practice, set standards for good practice for registered practitioners, investigate and adjudicate fitness to practice cases and, where relevant, sanction those practitioners who are found to have fallen short of these standards.

3.9 Potential outcomes of regulation in the context of patient safety

The justified and documented concerns about past and current failures in the delivery of healthcare as outlined in section 2.5.1 have prompted radical reforms to the regulatory frameworks governing healthcare professionals in the belief that this will prevent future failures (Cayton and Webb, 2014). It can be argued therefore that the potential outcomes of regulation are to strengthen both public protection and patient safety (Storey, 2007; Gould, 2013; Bradley, 2013). In fact, some view professional regulation as an additional layer of public protection beyond that afforded by ‘the market’, such that members of the public can now access and verify information on regulated practitioner qualifications (Granger and Watkins, 2013). Professional regulation is well recognised as a framework within which safe practice occurs and provides the patient and the public with essential regulatory safeguards (UK Department of Health, 2007). Included among these safeguards are the setting of high standards for the education and training of practitioners, controlled entry to

the professions, 'protection' of title, and promoting and enforcing codes of ethics and conduct (O'Shea, 2013). Therefore, according to Cornock (2008), if this regulation did not exist there would be no nationally agreed minimum standards for healthcare practitioners, no opportunity for the public to check whether healthcare practitioners are competent leading to a diminished form of public protection and patient safety. This position is supported by Allsop and Mulcahy (1996:1) who posit that regulation supports '*the need to protect the safety of patients; to promote best practice; to minimise risk; to manage error; and to make the best use of resources in the care of patients*'.

A key instrument of professional regulation in the protection of the public and patient safety is a centralised register of healthcare practitioners maintained by the regulatory body. Such a register of those entitled to practice can promote public protection and patient safety by providing a barrier to employment (McKenna et al, 2004; Storey, 2007; Griffiths and Robinson, 2010), and alerting employers to potential workers who may pose a risk to patients (McKenna et al, 2004; RCN, 2012).

For example, an employee may choose not to declare a past employer as a referee where they were subject to a charge of misconduct and therefore future employers would be oblivious to these past offences, thereby compromising patient and public safety (See for example Saks and Allsop, 2007). In contrast, under a regulatory framework, any misdemeanours or misconduct on the part of the healthcare worker will be recorded on a national occupational register together with any appropriate sanctions applied up to and including removal from practice (McKenna et al, 2004). Furthermore, this central regulatory control mechanism would facilitate transparency by allowing a member of the public, or an employer, to confirm that the healthcare practitioner is at that point in time registered with the relevant professional regulatory body and also allows the searcher to confirm the type of registration which the employee holds. Thus, those who claim to have registered status when they do not can be readily checked and confirmed as being unregistered.

There is also a suggestion that being professionally registered may also serve to prevent impaired care practices, as members are deterred by knowledge of the punishment imposed on those who fail to meet the required standards (Hand, 2011). Therefore, a mandatory register is viewed as necessary to halt the poor practice that puts patients and the public at risk (Griffiths, 2015).

A further potential outcome of regulation in the context of patient safety is the establishment and oversight of minimum entry educational requirements and competencies for healthcare practitioners that are necessary for achieving registration (Lepper, 2010; RCN, 2012). Thus, although healthcare practitioners may have been prepared for their practice by credible and competent clinicians, the fact that their practice and education are not regulated means that consistency of standards cannot always be guaranteed. Public protection is known to be increased when an established standard of competence in practice is required for entry to a register (Granger and Watkins, 2013). The professional regulatory bodies therefore set and regulate standards and guidelines for pre-registration education leading to admission to their respective registers, with agreed competencies for prospective healthcare practitioners overseen by a process of quality assurance (Lepper, 2010; RCN, 2012). By having supervisory authority over entry education, the patient and public are assured that the qualifications of the regulated healthcare practitioner could be certain, thereby giving the public the confidence that healthcare practitioners have been educated to the requisite level and are licensed to practise (Cornock, 2008).

Finally, it is argued that patient safety can be further enhanced through regulation by creating a national set of rules and standards, commonly referred to as a code of professional conduct (Vaughan, 2014). The code of professional conduct describes the standards of conduct, behaviour and attitude that the public and people who use health and care services should expect from healthcare practitioners (Skills for Care and Skills for Health, 2013). The code assures patients and the public that they will be treated by healthcare practitioners who will exhibit the core values of caring, compassion and commitment at all times as outlined by the Department of Health, Ireland (2016b). Furthermore, a code of professional conduct will also assist employers and managers to understand what standards to expect of healthcare practitioners and to identify the requisite supports when healthcare practitioners fail to meet the required standards. Such codes have recently been introduced for HCAs in Scotland (Birch and Martin, 2009) and England (Cavendish, 2013).

In summary, whilst professional regulation is not a panacea to prevent organisational or system-wide failure, it is however essential for holding its members to account ensuring that they discharge their professional responsibilities in a manner that users of their services would expect.

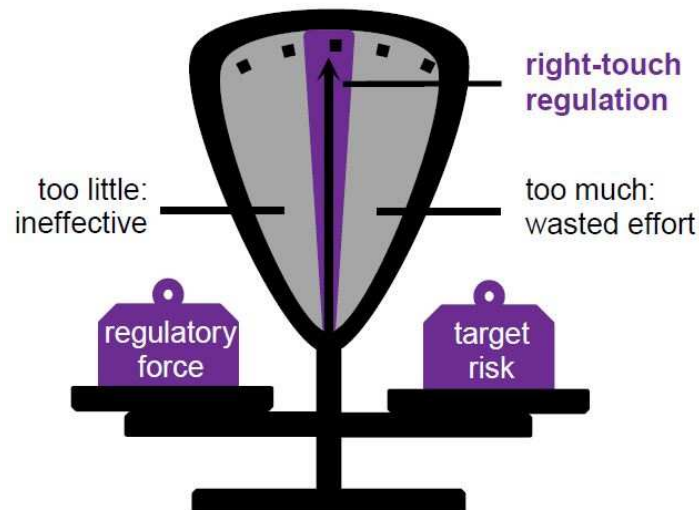
3.10 Re-thinking regulation

To continue to meet their obligations of public protection and patient safety, it is now broadly recognised that health professional regulatory bodies will need to review their roles in the light of major social, economic, and healthcare trends and make adjustments accordingly (Bayne, 2012). Worryingly for many, professional regulation is perceived to be overstretched in its scope, excessively expensive to operate, and demonstrating little evidence on its effectiveness and impact (Walshe and Boyd, 2007; Professional Standards Authority, 2015). Furthermore, there is a strong sense that while the delivery of health and social care are changing rapidly, regulation is not programmed to keep pace with these changes. Therefore, a more radical approach to regulation is required to meet the future demands of healthcare (Professional Standards Authority, 2015).

3.11 Right-touch regulation

One such concept introduced by the Professional Standards Authority (PSA) in the UK that is already gaining traction is right-touch regulation. Building on the principles of Better Regulation discussed above, right-touch regulation holds that only the minimum regulatory force that is required to achieve the desired result should be permitted and thus paving the way for a more balanced approach to healthcare regulation (Council for Healthcare Regulatory Excellence, 2010). Proponents of Right-touch view regulation as only one of many instruments for ensuring safety and quality and therefore that it must be used judiciously (PSA, 2014). This approach seeks to ensure that an acceptable balance is achieved between the two extremes of over-regulation on the one hand, which is seen by many as wasteful and interfering with personal conduct and individual freedom, and under-regulation on the other hand, which is viewed by some as an abdication of public responsibility by Governments (CHRE, 2010). See Figure 3-2 below.

Figure 3-2 Regulatory Force



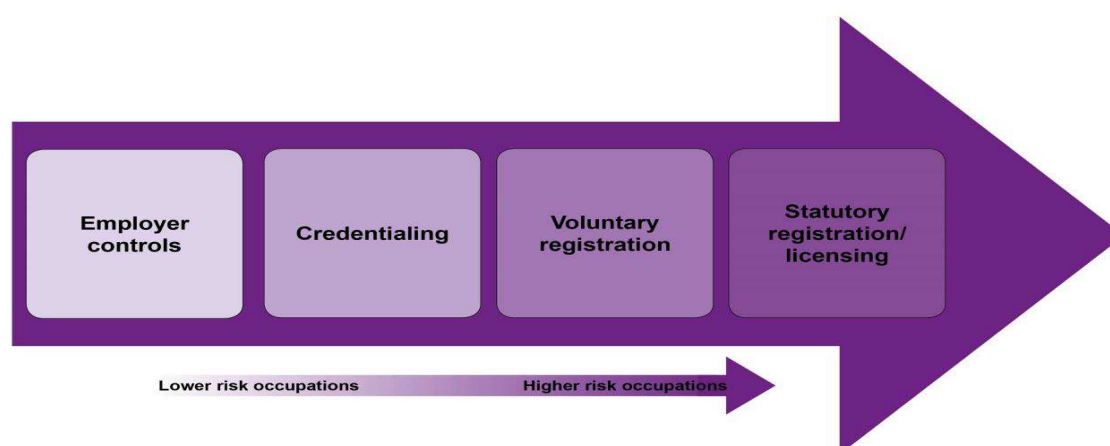
Professional Standards Authority (2015)

Encapsulating the five principles of Better Regulation, namely proportionate, consistent, targeted, transparent and accountable, the CHRE (2010) then added ‘agility’ as a sixth principle. This addendum to the Right-touch regulation principles was an acknowledgement of the tardiness of existing regulatory processes and a recognition that *‘regulators must be consistently in a state of readiness to respond to changes and developments in healthcare professional practice and circumstances’* (PSA, 2016: 3). Inherent in this approach is the recognition that there is usually more than one way to solve a problem and statutory regulation does not always present the best and most responsive solution (PSA 2015). Also implicit is acknowledgement that all healthcare interventions have an element of risk that cannot be totally eliminated and any decisions about what and how to regulate will involve a trade off between different risks and competing benefits. In practice, this means that a thorough risk-based assessment of problems should be undertaken at an early stage to ascertain the most appropriate level of intervention and, therefore, the best regulatory solution. Under this model, new regulations should only be introduced as a last resort when all other options have been explored and eliminated (O’Shea, 2013).

The PSA (2015) also make reference to ‘aspirant groups’ such as Physician Assistants which are new and emerging healthcare professional groups who claim that they already satisfy the necessary formalities for professional regulation. Some commentators also hold

that healthcare assistants are similarly recognised as an ‘aspirant group’ (Clark, 2014). However, caution should be exercised as many of these occupational groups view regulation as nothing more than ‘*a badge of professional status and something to be achieved, rather than a system to be applied where risks justify its intervention*’ (PSA, 2010: 9). Therefore Right-touch regulation holds that any decisions to regulate healthcare workers should be proportionate to the harm it is seeking to prevent. Under this model, statutory regulation should be preserved for those professions for whose practice presents the most significant risk to public protection (PSA, 2015). Figure 3-3 below provides the PSA (2016) continuum of assurance diagram which all healthcare professions both aspirant and existing will be assessed against to determine the form of regulation that may afford the requisite degree of oversight. As the level of risk increases, the regulatory force required to manage that risk also increases.

Figure 3-3 Continuum of Assurance



Professional Standards Authority (2016)

The following definitions apply to the terms used in the diagram:

- Employer controls - refers to any requirements that employers might put in place to provide assurance of minimum standards of practitioners such as training, qualifications, codes of conduct, supervision and appraisal;
- Credentialing - refers to developing a consistent method of validating the identity and legitimacy of external employees with access to healthcare settings;
- Voluntary registration - refers to the model through which professionals collaborate and agree a set of standards and practices and codes of conduct,

independent of Government or any statutory framework, for the purpose of raising standards and protecting the public. The profession itself takes responsibility for registering its members, setting standards, maintaining a register of practitioners and removing members who are considered to have fallen short of those standards. (Department of Health, UK, 2009);

- Statutory regulation and licensing - refers to the legal requirement for regulation of certain health care professionals whose practice presents a risk of serious harm to patients (PSA, 2016).

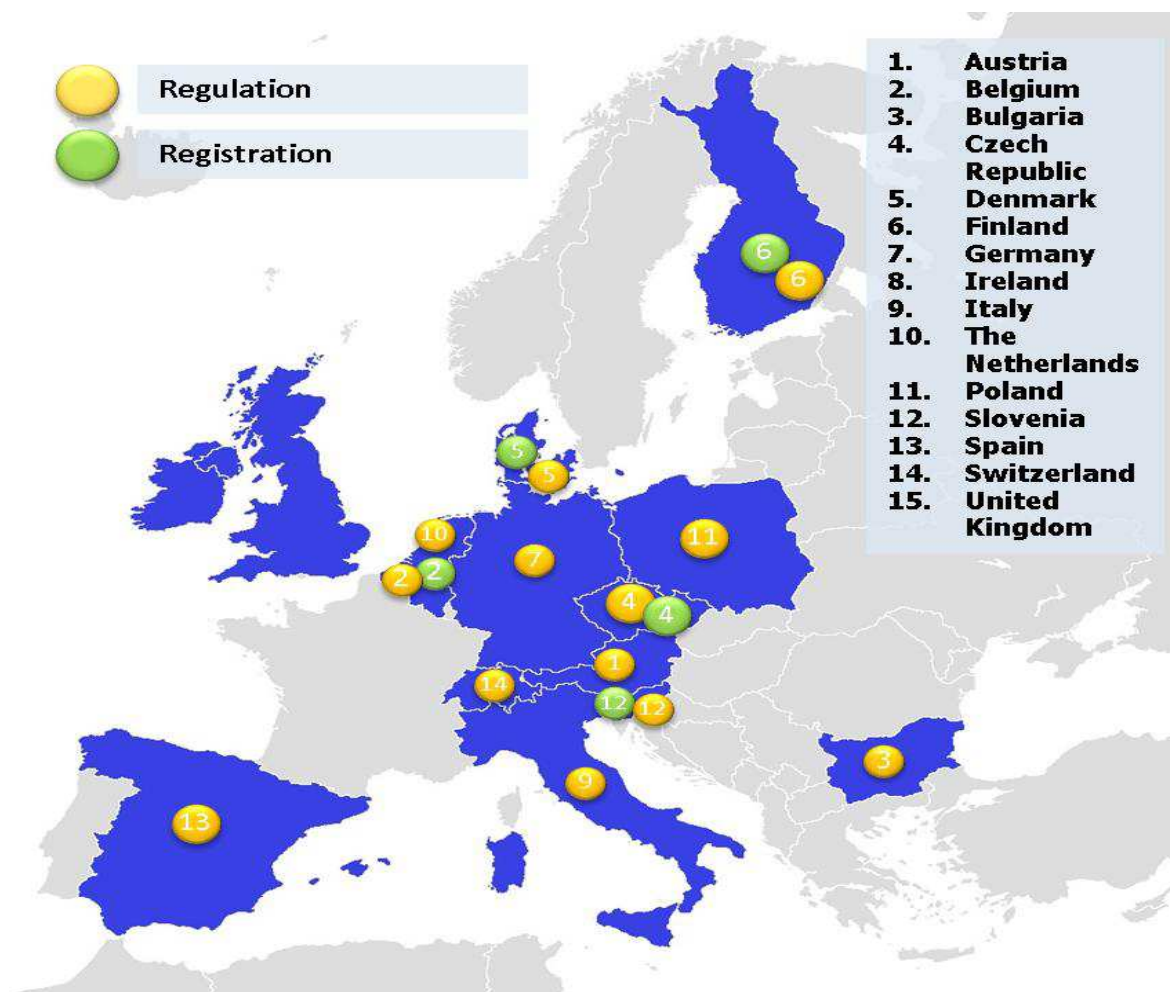
This overall approach focuses on the reduction of risks posed by occupational healthcare groups as opposed to the enhancement of their professional status (Cayton and Webb, 2014). Indeed, inherent within Right-touch regulation is the stipulation that alternative regulatory solutions such as voluntary registration must first be attempted, and their adequacy assessed before any alternative regimens such as statutory regulation will be considered by policy-makers (O'Shea, 2013).

Some commentators, however, have expressed a note of caution with the Right-touch approach. Lynne (2011), for example, observes that the introduction of multiple models of regulation as outlined above whereby regulatory authorities will be expected to hold statutory and voluntary registers will only add to public confusion by the existence of these differentiated registers. Furthermore, the approach may be viewed by the public as nothing more than a cost saving exercise by the Government who are abdicating their responsibility to protect the public by overseeing a disproportionately 'soft' approach to regulation (O'Shea, 2013).

3.12 Current discourse on extending professional regulation to HCAs

There is a small but growing body of empirical literature around the professional regulation of HCAs and related supporting roles. However, what emerges from the literature is the absence of debate in Ireland in relation to the regulation of these roles. Internationally, regulation of the HCA workforce is inconsistent, as is licensure of individual HCAs, whether optional or mandatory (Hewko et al, 2015). However, in a recent EU commissioned study, Braeseke et al. (2013) reported that only 3 of the participating European countries in the study do not have an official regulation of the healthcare assistant workforce, namely Ireland, Switzerland and the United Kingdom. See Figure 3-4 below.

Figure 3-4 European countries where HCAs are regulated or registered



Adopted from Braeseke et al (2013)

In the countries with the green dots there is mandatory registration for the workforce whilst in countries with the yellow dots the HCA occupational group is officially regulated.

In Ireland, there is limited understanding of the value or otherwise to the public interest by regulating this workforce. Nevertheless, some commentators point to a perilous lacuna in the healthcare system whereby the work and practices of front line HCAs remains unregulated (McKenna et al, 2004). In the UK, despite persistent calls made for the regulation of HCAs (Johnson et al., 2002; Glasper, 2012; McIntosh and Holland, 2012; Francis, 2013), the role largely remains unregistered.

I identified seven studies relating predominantly to a discourse on regulation of HCAs, as well as published Government reports that also have a regulation related aspect.

For example McKenna et al. (2004) in reviewing the literature surrounding the role of the HCA with regard to patient safety and quality of care observe that a lack of systematic training, lack of clear role boundaries and lack of regulation as key issues underpinning serious concerns relating to this workforce and consequences for patient safety.

Furthermore, the authors point to a number of loopholes in the system arising from the lack of HCA regulation to include the absence of a centralised register or hub to validate the competencies and credentials of new employees and check a HCA's criminal record. In support of this position, the authors highlighted well publicised cases whereby patients were subjected to physical abuse at the hands of HCAs and reports of nurses who had their registration withdrawn by their regulatory body but then began working as HCAs unchecked by the new employer (ibid). In concluding, they hold that the absence of regulation for HCAs is putting patient safety and quality at risk. Whilst, the arguments are well presented in favour of HCA regulation, some commentators suggest that these views may suffer from a nursing bias (Centre for Allied Health Evidence, 2006).

Meanwhile Saks and Allsop (2007) investigated the requirement and extent of regulation of healthcare support workers in the UK and the practical means of providing it, taking account of all of the costs and benefits. This large scale study included NHS chief executives, owners and managers of nursing homes, service users and support workers themselves. Echoing McKenna et al (2004), its findings revealed support from chief executives for the regulation of support workers including *“a mandatory register; codes for workers and employers; formal education levels; pre-service checks; and access to information on those unsuitable for employment”* (Saks and Allsop, 2007: 172). The support for a centralised register was equally consistent with other survey respondents. The register was viewed as an effective feature of a regulatory framework to combat concern of unsuitable individuals moving between employers and consequently working with vulnerable patients unchecked. Challenges to the introduction of regulation for this workforce included additional costs to employers, the Government and those to be registered. It was also suggested that some support workers may resist regulation. Although the study drew on a wide body of opinion to inform the findings it was disappointing to discover the low response rate at 15% from the chief executives to the survey.

The current unregulated status of the HCA has also attracted the attention of the Nursing and Midwifery Council of the United Kingdom who commissioned Griffiths and Robinson

(2010) to undertake a scoping review of the risks associated with the increasingly extended role. The authors acknowledge that whilst not subject to statutory regulation, the HCA role does already enjoy a measure of regulation in the form of safeguarding checks and opportunities for professional development. The final report summarised the evidence of whether the unregulated HCA presents a risk to public safety in terms of uncontrolled access to employment, lack of standardised competencies and mandatory education, and lack of supervision of extended tasks undertaken by HCAs (ibid). Though the authors present a strong case in favour of HCA regulation, it was not possible to state with certainty that the unregulated HCA role presents a risk to public safety.

However, not all commentators concur with the findings and recommendations in the previous three studies and some question whether regulation is a proportionate response to the risks presented by the HCA workforce. Youg (2008), for example, was courageous in her public opposition to any suggestion that HCAs should be regulated, a position that was in direct conflict with her employer, the Royal College of Nursing (RCN). In contrast to the previous studies she questions the ability of regulation to protect the public and points to regulated professionals such as Dr. Harold Shipman and Nurse Beverley Allit who fatally damaged patients in their care. Furthermore, she observes that in contrast to registered nurses, HCAs are not expected to exercise complex clinical judgement and decision making or delegate care activities to other team members. In addition, the author raised concerns that regulation of HCAs would prompt the leaders of healthcare services to replace registered nurses with HCAs in a cost saving exercise to the detriment of quality of care (ibid). These views find an echo with other commentators (Braithwaite, 2010; Calkin, 2011; Royles, 2011).

More recently, the chief executive of the NHS dismissed calls from senior nurses for HCAs to be regulated claiming that the time, effort and costs invested in establishing a national register would be better employed in further education and training of this workforce (Calkin, 2011). These commentators are not alone in their scepticism of professional regulation. In fact Quick (2011) was left frustrated by the thin state of hard evidence around how professional regulation impacts on professional behaviour, given the multitude of other sources of influence. These alternative sources of influence on professional behaviour include among others, organisational guidelines, legislation, employment contracts, peer support/pressure and therefore render it difficult to single out the impact of professional regulation. Similar findings were reported by Vaughan et al.

(2014) and concluded that debates on professional regulation of HCAs are premature until the aforementioned mechanisms are fully utilised and assessed for impact.

Nevertheless, a sense of disquiet prevails in the literature regarding the absence of regulation for HCAs. More recent studies continue to heighten the need for some form of professional regulation for this workforce. Australian research undertaken by Duffield et al. (2014) presented a review of the global arguments relating to HCA regulation. In support of their position for the regulation of HCAs the authors point to the model of substitution of registered nurses with unskilled assistant staff in the UK that resulted in increased morbidity and mortality rates of service users. Similar to Storey (2007), the authors also argue that regulation would provide greater role clarity for the HCA and the delegating nurse and support HCAs to continue to work within their sphere of competency, thereby providing additional assurances and protection for the public. In concluding, the researchers warn that the calls for regulation will become increasingly persistent as HCA workers continue to grow in proportion to the overall healthcare workforce (Duffield et al, 2014).

The largest and most recent scoping review of HCA workforce literature to date was undertaken by Hewko et al (2015) in the United States. The researchers were prompted by perceived knowledge gaps in the HCA workforce literature that echoed similar claims by previous commentators (Braeseke et al., 2013). Of particular concern was the relative invisibility of this workforce to researchers, patients and the general public as a consequence of their unregulated status (ibid). The authors argue for professional regulation or at a minimum a national register of HCAs for each country to establish reliable baseline demographic data that will lead to a better understanding of the workforce.

3.13 Summary of literature on professional regulation

To summarise, this final section of the literature review chapter has explored the nature of professional regulation and its role in protecting public interest. The regulatory landscape in Ireland was also examined and demonstrates an upward trajectory in the number of regulatory agencies to emerge over the past twenty years, suggesting a greater reliance on state regulation. Regulatory policy in Ireland has been primarily influenced by the ‘Better Regulation Principles’ adopted in 2004 with the emphasis on balancing the costs of regulation with the benefits it confers. Professional regulation in healthcare has been shaped by several high profile scandals involving professional healthcare staff. As a

consequence, the regulations governing the oversight of healthcare professionals in Ireland were amended in order to hold the relevant regulatory authorities more accountable to the public.

Professional regulation continues to be viewed as extremely expensive to operate, inflexible and with little evidence on its effectiveness and impact. Consequently, Right-touch regulation is gaining traction and holds that only the minimum regulatory force that is required to achieve the desired result should be applied paving the way for a more balanced approach to healthcare regulation.

However, a small but growing body of literature is emerging that suggests that there is a significant place for the regulation of HCAs in the drive to improve patient safety. Whilst some authors have expressed caution that the regulation of this workforce will not have the desired impact on public protection, the majority of studies examined have argued in favour of a more robust governance through regulation. The principal concerns that can be addressed through regulation include: the prevention of unsuitable employees moving between employers and working with vulnerable patients unchecked; standardisation of entry requirements and training; a standardisation of work practices and subsequently greater role clarity for HCAs and registered nurses.

3.14 Conclusion

In this chapter, I set out to review the pertinent literature relating to a range of themes relevant to my research aims and objectives. The definitions and models of professional regulation employed in Ireland and internationally and the current discourse in respect of regulation of HCAs were also examined. In particular, the review aimed to give an understanding of those events that have led to a loss in confidence among the general public and the government in the regulatory systems of governance for health professionals. Reforms to the process of regulating healthcare professionals arising from national scandals are viewed as attempts to restore public trust and confidence in regulatory authorities. The presentation of this literature review was underpinned by the theoretical constructs of public interest and public choice.

This literature review has also revealed a paucity of empirical literature in this area with what exists generally focusing on education and training of HCAs. With the exception of Saks and Allsop (2007), the majority of the literature pertaining to the regulation of HCAs

is limited to systematic reviews or commentary in nature. This lack of literature pertaining to HCA roles particularly in relation to professional regulation in Ireland demonstrates a limited consideration regarding the value of this workforce and therefore is an area worthy of further investigation. While the above is not an exhaustive list of empirical research that has been undertaken it is nonetheless comprehensive and points to the need for a larger evidence base regarding the professional regulation of HCAs, especially in the Irish context.

The key issues emerging from the literature review have been used to inform the development of my research questions for the data collection and primary research undertaken. Having identified the key gaps in the literature on professional regulation and HCAs in Ireland that will be examined in the research phase, this thesis now moves on to set out the research process and methodology utilised in this study in Chapter 4.

Chapter 4 Methodological Approach

4. 1 Introduction

The previous chapter has set out the current debates surrounding the role of the HCA in the Republic of Ireland and the potential requirement for professional regulation. The purpose of this chapter is to describe in detail the methodological approach that was chosen for this research. It commences with a consideration of research philosophy, outlines the reasons for using a qualitative approach, and provides a rationale for choosing case study as the most appropriate methodology for the research.

The process of developing the data sample is described, followed by relevant information on the research participants and the process of participant recruitment. This is followed by a description of the design and implementation of the data collection process that includes data collection methodologies, utilisation of semi-structured interviews, focus groups, interview scheduling, pilot interviews, the completion of participant interviews and document analysis. A section on data analysis techniques to include template analysis and coding is followed by details of the evaluation of the trustworthiness of the research to include reflexivity. The final sections in the chapter address ethical considerations, issues relating to the trustworthiness of the research, the limitations of the study and a summary of the key points. In the interest of coherence, I again set out the aim and objectives for the study below.

4.1.1 Aim and Objectives

The aim of the study is:

To explore the changing role of healthcare assistants in Ireland and consider the need for professional regulation in the public interest

The objectives of the research are to:

- 1 Undertake an in-depth critical review of the extant published literature regarding unregistered HCA staff and the relevant discourse regarding professional regulation

- 2 Seek to understand the views of the healthcare assistants in respect of their changing role and subsequent future regulation for their profession
- 3 Assess the views of other key stakeholders in Ireland in respect of proposed introduction of healthcare assistant regulation
- 4 Identify the risks if any associated with this workforce continuing to provide front line clinical care while unregulated

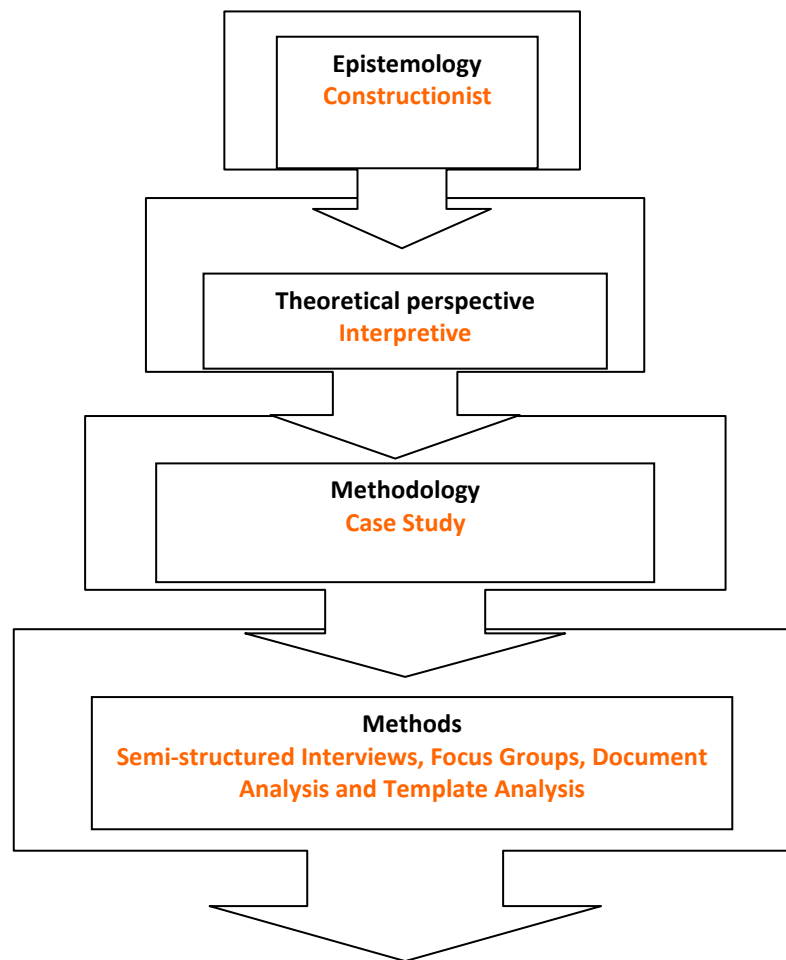
4.2 Design

A range of research options were considered for this study with a view to finding the best fit to address the aforementioned research objectives. This began with an exploratory quality research study, which was designed to meet the research aim and was considered from a contextual constructionist position. The research methodology follows the work of Crotty (2010: 3) who suggests the importance of four key interconnected elements when designing a research study. The four elements are:

1. *‘Epistemology – the theory of knowledge embedded in the theoretical perspective and thereby in the methodology;*
2. *Theoretical perspective – the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria;*
3. *Methodology – the strategy, plan of action, process or design lying behind the choice and use of methods and linking the choice and use of methods to the desired outcomes;*
4. *Methods – the techniques or procedures used to gather and analyse data related to some research question or hypothesis.’*

Crotty’s theoretical framework has been adapted in Figure 4-1 below to represent the above elements and my research design. It provides a useful mechanism to tie together the philosophical issues, theoretical perspectives, methodology and methods of social research as well as interrelating the four components of the research process.

Figure 4-1 Crotty's Theoretical Framework



Crotty, 2010

These elements are now critically discussed in order to highlight the research approach and methods, which were selected for the purpose of addressing my research objectives. In particular Crotty's theoretical framework provides a stimulus to consider my own perspective of the world, how knowledge is obtained, the nature of reality and ultimately the underpinning philosophy to guide this research study.

4.3 Epistemology and Ontology Position

Guba and Lincoln (1998: 195 cited in Doolan-Grimes, 2013) hold that '*questions of method ought to be secondary to questions of paradigm, which is defined as the basic belief system or world view that guides the researcher, not only in choices of method but in ontologically and epistemologically fundamental ways*'. The rationalisation for the selection of the methodology and methods challenges the researcher's suppositions about

reality (Crotty, 2003); thereby providing an explanation for the way the study has been conducted.

The epistemological and ontological views of the researcher will therefore dictate the choice of methodology (Briggs et al., 2012). Thus, at the outset, I have committed to exploring and clarifying my own view of the world in terms of how knowledge is acquired (epistemology) and the nature of reality (ontology) (Creswell and Clarke, 2007). In considering these paradigms, I was drawn to the position taken by Crotty (1998), who acknowledges his omission of ontology from the research process and instead combines it with epistemology declaring that there is a blurring of the boundaries between both conceptually when discussing matters of research: *‘to talk about the construction of meaning [epistemology] is to talk of the construction of a meaningful reality [ontology]’* (Crotty, 1998: 10). Hence, ontology is not included in Crotty’s schema above. Adopting this perspective, below are my epistemological commitments, followed by a reflection on the way in which I understand epistemology and methodological decision making to be interconnected in the process of research design.

Epistemology has been defined as the science of knowledge and it is a way of understanding and explicating *‘how we know what we know’* (Crotty, 2003: 8). Three epistemological constructs proposed by Crotty (1998) were objectivism, subjectivism and constructionism. Each epistemology contains assumptions about the nature of the world and these assumptions are then ingrained in the particular methods. In providing an outline and rationalisation for the preference of constructionism for this study, it is also considered appropriate to briefly outline the other two constructs together with their associated assumptions and limitations in their application to social world research.

4.3.1 Objectivism

Objectivists *‘...hold that meaning, and therefore meaningful reality, exists as such, apart from the operation of any consciousness’* (Crotty, 1998: 8). The central tenets of objectivism, therefore, are that meaningful reality exists independently of perception and experience, and the properties of an object being examined can be measured and quantified. Researchers adopting this perspective hold that it is possible to discover objective reason and truth from their research (Crotty, 1998). I did not believe that rigorous interviews with HCAs, senior managers and policy makers would render an objective truth in respect of the requirement for professional regulation.

Objectivism was considered but abandoned as possible research epistemology for this study. The underlying philosophical assumptions that the research methodology should be determined by objective criteria, unaffected by human perceptions or interpretations does not fit with the explorative nature of this research.

4.3.2 Subjectivism

Subjectivism maintains that meaning '*does not come out of interplay between subject and object, but is imposed on the object by the subject. Here the object as such makes no contribution to the generation of meaning*' (Crotty, 1998: 9). Subjectivism as an epistemology is frequently aligned to constructionism but consists of meaning which is not actively constructed but which emerges from our subconscious, dreams and spiritual beliefs or '*...that is to say meaning comes from anything but an interaction between the subject and the object to which it is ascribed*' (Crotty, 1998: 9). As an epistemology, subjectivism does lend itself to the qualitative and exploratory nature of my study, however, I posit that reality and meaning must be generated from the perceptions of the HCAs, senior managers and policy makers by focusing on their own prior experience, knowledge, and expectations as opposed to sub consciousness, dreams and personal belief systems only.

4.3.3 Social Constructionism

Social constructionism is an epistemological view that knowledge is developed and our realities are shaped through our experiences and our interactions with others. It is argued (see Crotty, 2003 cited in Doolan-Grimes, 2013) that social constructionists generate meaning as a result of the interplay between subject and object:

There is no meaning without a mind. Meaning is not discovered, but constructed. In this understanding of knowledge it is clear that different people may construct meaning in different ways, even in relation to the same phenomenon. In this view of things, subject and object emerge as partners in the generation of meaning. (Crotty, 1998: 8).

In considering this study and the proposed epistemology, it was my position that the participants concerned i.e. HCAs, senior managers and policy makers were the sources of knowledge regarding the research aim. This knowledge may vary between the participants

(i.e. between HCAs and senior managers, between senior managers and policy makers, between different HCAs, different senior managers etc) with the consequence that meaning and reality may be constructed in different ways. Knowledge may also vary due to the histories, experiences, perspectives and roles of the various participants. As a representation of my own world view, I could identify with the social constructionist paradigm, as developed by Crotty (1998), that there is no objective truth to be discovered, but that we determine our own reality and construct our own knowledge and understanding of various phenomena through our engagements with life experience and situations. This view was shaped in my early career as a mental health nurse. Such are the complexities and unknowns associated with mental illness and the human mind, it can be difficult to arrive at a single cause or diagnosis for individuals suffering from a mental health breakdown. Thus, in my early role, I was often faced with challenges of caring for people with multiple complexities and possible causes of illness. As a consequence and in accordance with the social constructionist position, multiple outcomes and ‘truths’ are a reality for me.

An epistemological position of social constructionism was therefore adopted for this study to best address the proposed research objectives as the individual healthcare assistants’ perceptions and those of other key stakeholders of professional regulation will be influenced and shaped by many internal and external factors, including their own personal beliefs, prior experience, knowledge and expectations. Therefore, the philosophical assumptions associated with social constructionism inform this study as multiple realities or differing interpretations of realities regarding the regulation of the HCA role in Ireland are constructed.

4.4 Theoretical Perspective

Having determined the epistemological position for this study as being social constructionist, this chapter will now turn to outline the key theoretical and methodological considerations. The theoretical perspective can be described as a set of basic philosophical assumptions that in turn informs the methodological decisions and consequently the methods used by the researcher to collect data (Crotty, 2003).

There are two main types of theoretical perspectives:

- ♦ Positivism - with an emphasis on objectivity and verifiable knowledge claims;

- ♦ Interpretivism - encompassing hermeneutics, social constructionism and symbolic interactionism - with an emphasis on a constructionist approach to knowledge.

Positivism is based on the premise that *'objective accounts of the real world can be given'* (Denzin and Lincoln, 2005:27). Quantitative research methods have been described as being embedded in positivism. The theoretical perspective, positivism, is aligned to the epistemology of objectivism, assuming that researchers have the *'capacity to uncover a singular knowable reality through pure understanding and rigorous intellectual reasoning'* (Grbich, 2013: 6).

Positivism and objectivism cultivate a co-dependence relationship whereby if a positivist theoretical position was established, then an objectivist epistemological stance would follow (King and Horrocks, 2010). According to Langridge (2007) positivist paradigms have little relevance to the study of social sciences and human nature and therefore have been rejected for this particular study.

In contrast to positivism, the interpretivist approach holds that individuals do not have access to the real world, indicating that their knowledge of the perceived world (or worlds) is meaningful in its own terms and can be understood through the use of interpretivist procedures (Carson et al., 2001). In support of this position Prasad (2005: 13) declares that *'all interpretive traditions emerge from a scholarly position that takes human interpretation as the starting point for developing knowledge about the social world'*. The interpretive researcher acknowledges that perceptions of reality can vary between individuals and encourages participants to share their experiences and observations.

The interpretative approach has its roots in the sociology of Max Weber (1864-1922), who was interested by the idea that social sciences embrace the notion of understanding (Verstehen) of multiple constructed realities in contrast to explanations (Erklaren) found in natural science (Crotty, 1998; Bryman and Bell, 2015).

Qualitative approaches as opposed to quantitative are generally linked to interpretivism and constructionism with a focus on the quality and richness of the data collected. Coming from a constructionist epistemology and taking account of the purpose of this thesis and

the objectives outlined, the philosophical assumptions associated with the interpretive perspective inform this research.

A qualitative approach to this research was considered appropriate for two main reasons, firstly, my study is exploratory, rather than testing a defined hypothesis. Secondly, my objectives require multiple participants' constructed perspectives to be explored in depth and detail. A qualitative approach to the research enabled me to engage with the research participants in order that they could actively reflect on their accounts, allowing me to probe and prompt for further meaning and reflection. This would not have been achievable using a quantitative methodology.

4.5 Research methodologies (Case Study Approach)

Stemming from the epistemology and theoretical perspectives outlined above, the research methodology that appeared to be most appropriate for this thesis was case study. The case study approach adopted is from Yin (2003, 2009, and 2014) and is firmly rooted in an exploratory case study model. Whilst acknowledging that his work is orientated towards a realist perspective Yin does contend that *'...case study research also can excel in accommodating an interpretivist perspective – acknowledging multiple realities having multiple meanings, with findings that are observer dependent'* (Yin, 2014: 17). The case study design is therefore used to generate an in-depth understanding of the requirement or otherwise for the regulation of HCAs. The case study approach also has precedent with regard to investigations into regulation (Horwitz, 1989).

The case study methodology has a long and distinguished history within social science (Yin, 2003; Creswell, 2009). Case studies allow the researcher *'...to probe deeply and analyze the phenomena that constitute the life cycle of the establishment with the view to establishing generalizations about the wider population to which that unit belongs'* (Cohen and Manion, 1989: 124-5). Stake (1995) defined the case study as a generic term for the investigation of an individual, group or phenomenon that is characterised by the use of multiple methods for data collection.

More recently, Yin (2009: 18) described a case study as *'An empirical inquiry about a contemporary phenomenon, set within its real-world context especially when the boundaries between phenomenon and context are not clearly evident'*

Four types of case study designs are posited by Yin, (2014): single-case (holistic) design; single-case (embedded) design; multiple-case (holistic) design; multiple-case (embedded) design. This study adopts a single-case (embedded) design, and Section 4.5.1 below provides a justification for the selection.

4.5.1 Justification for the Single-Case (Embedded) Design

As outlined in the previous section, a case study can offer valuable insights into the requirement or otherwise for the regulation of HCAs as it has particular strengths when a researcher seeks to illuminate a specific situation and get a close understanding of the phenomenon (Yin, 2004).

Yin (2003) argues that the single-case is an eminently justifiable design under the following circumstances:

- ♦ It represents the critical case in testing existing theory;
- ♦ It is an extreme or unique case;
- ♦ It is a revelatory case by offering the researcher an opportunity to observe and analyse a phenomenon previously inaccessible to investigation;
- ♦ It is an exploratory case and therefore the prelude for further studies.

The rationale for adopting a single-case study design is based on the exploratory nature of this study and the lack of research and discourse regarding professional regulation for HCAs in Ireland. Context and situations are important elements of a case study. The case has its own unique history as outlined in Chapter 2 and operates within a number of contexts such as institutional, economic, legal, administrative, hierarchical, and ethical. In order to make sense of these contexts and to enhance the insights into this single case, an embedded single case analysis was used (Yin, 2014). Furthermore, adopting this design enabled multiple perspectives of a range of stakeholders associated with the HCAs and the requirement for regulation to be captured.

This is considered an appropriate approach due to the lack of current qualitative empirical research in this particular area in Ireland, allowing me to explore the field and gather

meaningful data regarding individual and group experiences. Furthermore, commentators argue that the case study researcher often feels inherently stimulated to investigate a particular case. If there is an intrinsic interest the researcher takes responsibility and is accountable for the analysis and its consequence (Gibbons et al., 1994). In this study I am intrinsically stimulated to gain and contribute to knowledge, as outlined under Section 1.4 of the thesis, detailing my personal interest and motivation for this study.

Multiple methods of data collection and triangulation have been used and this includes obtaining data from annual reports, focus groups and in-depth interviews and employing triangulation to gain greater insight into the question of professional regulation for HCAs in Ireland. Consequently, a holistic case study design was rejected for this research because of its propensity to lack depth in analysis of specific phenomenon and sufficiently clear measures or data (Yin, 2014).

4.5.2 Bounding the Case

The unit of analysis for this research is therefore the HCA occupational group. Yin describes the characteristics of a case study approach as one where the object of the study (unit of analysis) is a specific, unique bounded case. In this study, the persons to be included within the HCA occupational group (the immediate topic of the case study) must be distinguished from those who are external to it (the context of the case study). For the purpose of this thesis, the unit of analysis is confined to HCAs, both trained and untrained, who work in the public and private healthcare systems in the Republic of Ireland and report directly to nurses. This will exclude all other related grades and HCAs who report to non-nursing and non-midwifery professionals e.g. Home Help staff, Physiotherapy Assistants, Multi-Task Attendants etc. The case is also bounded by time as the investigation does not pre-date 1998, the year the HCAs were formally recognised in Government policy with the publication of the Commission on Nursing.

4.5.3 Limitations of Case Study Methodological Approach

Despite the strengths associated with case study design, methodological concerns have been voiced about the value of case study findings. Yin (2014) contends that the researcher '*should understand and openly acknowledge the strengths and limitations of a case study research*' (ibid: 4). The limitations include: the lack of representativeness of the case; lack

of rigour in data collection and the introduction of bias from the researcher or research participants; and a lack of generalisability from case findings (Holloway and Wheeler, 1996; Silverman, 2013). However, Flyvbjerg (2006) describes these limitations as nothing more than misunderstandings of the case study approach and readily corrects them one by one. Indeed, Flyvbjerg, (2006:227) argues that case studies provide an opportunity for generalization and it does not mean that case-study knowledge ‘*cannot enter the collective process of knowledge accumulation in a given field or in society*’.

The researcher will therefore seek to make generalisations, but these will largely be in relation to events and issues within the case itself, relative to the future of the case and new situations that may arise (Stake, 2003). Furthermore, Stake (1998) refers to the use of thick descriptions in a case study which may enable the findings of the study to have resonance with the reader to relate to particular elements within the findings or make comparisons between findings and other research fields.

4.6 Research Methods

As noted, the design of this research was determined by the theoretical propositions of public interest and public choice together with my epistemological position and the explorative nature of this study. The study makes use of qualitative data as opposed to hard empirical statistical tests. Central to this is the complex nature and phenomenon of regulation leading to the use of an embedded single case analysis based on a range of data sources as noted above.

4.6.1 Overview of Data Collection Methods

The data were primarily collected in two distinct but sequential stages as follows:

Stage 1: Four focus groups (including one pilot) were undertaken with HCAs (n=34) across three Health Service Executive regions nationally as follows:

HSE West – 1 focus group (n=9) and 1 pilot (n=4)

HSE South – 1 focus group (n=8)

HSE East (Dublin) – 1 focus group (n=13).

The purpose of these focus groups was to better understand the perceptions and experiences of HCAs working in the Irish healthcare system and why the role should or should not be subject to professional regulation in the future. The following literature review themes were explored:

- ♦ The nature of the HCA role
- ♦ Relationships with other healthcare workers
- ♦ Risks and patient safety
- ♦ Access to information
- ♦ Proposed professional regulation

The focus groups were conducted between the months of April and August 2015. The data collected for this stage were used to generate the questions aligned to the five broad themes identified above for the semi-structured in-depth interviews with senior key stakeholders.

Stage 2: In-depth interviews were subsequently undertaken with the relevant key stakeholders (n=13). Saunders et al. (2007) suggest a research interview is a purposeful discussion between two or more people and a semi-structured interview generally consists of a list of themes and questions to be covered. This is reinforced by Patton (2002) who emphasises the importance of probing to yield in-depth responses about people's experiences, perceptions, opinions, feelings, and knowledge.

The categories of relevant key stakeholders that were considered subjects for the research to be conducted were as follows:

- 1) Policy Makers;
- 2) Senior Service Managers;
- 3) Regulators;

- 4) Educationalists;
- 5) Trade Union leaders;
- 6) Patient Representative Association;
- 7) Nursing Homes Ireland;
- 8) Private Home Care Support Agency;

Any national decision on the regulation or otherwise of HCAs will be influenced principally by the members of these categories of stakeholders. For that reason they constituted important targets for the primary research conducted as part of this study. The Private Home Care Support Agency was only added to the above key stakeholder list following stage 1 data collection with focus groups as a consequence of concerns expressed in these groups regarding lone workers providing domiciliary care to vulnerable people.

4.6.2 Negotiating Access and Scheduling Focus Group Meetings and Interviews

Denzin and Lincoln (2013) describe gaining access to research settings and participants as sensitive which requires the researcher to establish trust and connection with the research subjects.

The importance of gatekeepers in this process has also been illuminated by Pope and Mays (2000) who describe their role as allowing and facilitating access to the research environment. This was particularly relevant for healthcare assistants for the focus group interviews. Having received ethical approval from Northumbria University on 22nd April 2014 and Health Service Executive ethics committee on 26th September 2014, I proceeded to send emails to Directors of Nursing and Midwifery as gatekeepers, for negotiation of access to HCAs in their work locations. The Directors of Nursing and Midwifery responded with letters and emails as appropriate, welcoming the research and approving access for me to the population of HCAs without any additional conditions attached. The Director of Nursing and Midwifery approval was critical to facilitate the release of HCAs to attend the focus groups during working hours. I was aware that the ever increasing

workload together with staff shortages would present significant challenges to managers to release the staff.

However, the approval of the Directors of Nursing and Midwifery provided assurance to me that the study was of value to the service. A letter of introduction requesting their participation was sent to potential participants in both focus groups (Appendix 2) and semi-structured interviews (Appendix 3). This letter was accompanied by information sheets (Appendix 4 and Appendix 5), which contained a brief description of the research and how the focus group or interview would be conducted.

The information sheet also highlighted that that the focus group or interview would be recorded and transcribed by the researcher. Furthermore, the participants were re-assured that their partaking was totally voluntary and that they were free to withdraw from the research at any time.

When scheduling the focus groups and the semi-structured interviews, I adhered to the principle espoused by Yin, (2014: 88) in respect of case studies that '*you must cater to the interviewees' schedules and availability, not your own*'. Focus groups were conducted in Centres for Nursing and Midwifery Education (n=3), a location familiar to most HCAs where they would have undertaken their FETAC level 5 HCA training. It was also an attempt to alleviate any anxieties experienced by the HCAs, diminish any sense of power and control differentials in the focus group interviews and engage the participants in the work. This will be discussed further under ethical considerations.

As the participants involved in the semi-structured interviews were all senior members of staff within their organisations, the researcher as an Area Director made direct contact with these candidates without the requirement of negotiating with a gatekeeper. The interviews were, for the most part, held in the interviewees' office and were conducted on dates and times that suited the interviewees. Finally, a letter of thanks with a copy of the transcript was sent to all participants on completion of the focus groups and interviews (Appendix 6).

4.6.3 Ethical Considerations

Normand et al. (2003) suggest four ethical principles relevant to research undertaken on human beings: non-maleficence (do no harm); beneficence (do positive good); autonomy

(show respect for rights of self determination); and justice (treat people fairly). I have strived to uphold these ethical principles in the design of this case study.

4.6.4 Ethical Approval

Before commencing the study approval was sought and gained from the research ethics committee, Northumbria University on 22nd April 2014 (Appendix 7). Burgess (1984) refers to those who control access to research populations as gatekeepers. The research ethics committees for the Health Service Executive, Ireland are the main gatekeepers for any proposed clinical or healthcare related research. It was necessary, therefore, to submit a more detailed application for approval to the Health Service Executive research ethics committee in Ireland which was approved on 26th September 2014 (Appendix 8).

In qualitative research there is an onus on the researcher to be aware of sensitive issues and potential conflicts of interest between the pursuance of rich data and maintaining and protecting the rights of the participants in the research (Arksey and Knight, 1999). I was acutely aware of my position in the organisation in comparison to that of healthcare assistants who have relative lack of power in political hierarchal organisations within the health service. The challenge for me as a moderator of the focus groups, therefore, was to minimise the negative impacts of power and control differentials in the focus group interviews and actively engage people in the work.

I was therefore obliged to explain within my submission how I could provide assurance that no harm would come to any participant involved in the study. Consequently, I assured the ethics committee that focus groups and semi-structured interviews would adhere to the principles of respect, empowerment and equality (Olesen, 2000; Cohen et al., 2003). I also engaged the services of the healthcare assistant education co-ordinators with whom the HCA participants would have an established relationship to assist with the facilitation of the focus group sessions and thus addressing the perception of an asymmetrical relationship between a powerful researcher and a vulnerable research subject (Murphy and Dingwall, 2007).

4.6.5 Informed Consent

Informed consent is one of the core ethical principles of conducting research with human participants and with named data (Research Ethics and Governance Handbook,

Northumbria University 2012: 3). It implies that the researcher is sincere in their efforts to ensure that the participants are aware of the risks as well as the benefits of participating in the study. The relevant information is presented objectively, without coercion and participants are made aware of their rights to withdraw from the research (Parahoo, 2014). Consequently, all participants were made aware of their rights to withdraw from the study at any time and documented on the information sheet.

4.6.6 Privacy and Confidentiality

I am aware that the confidentiality and anonymity of research participants together with the information supplied must be respected (Silverman, 2013). However, as I was employing interviews and focus groups which involved face to face meetings, anonymity to the researcher was not possible. In fact, in the case of focus groups, people other than the researcher are also present and aware of the involvement of an individual research participant (Berg, 1998). The participants were therefore assured that a high degree of anonymity in the study would prevail by taking all necessary steps to ensure that the identity of individual participants was not possible to determine from the findings of the research.

Consequently, the identities of the research participants were not included in the resulting transcripts. I conducted and transcribed all the interviews from a digital voice recorder. The interview recordings were stored on my encrypted laptop and password protected in accordance with the Data Protection Act (Government of Ireland, 1988). Hard copy transcripts were stored in a locked cabinet in my office.

An important dimension to the ethical conduct of this study was the question of the relationship between the researcher and the participant. This can be particularly sensitive when the researcher is in a formal position of power (relating to his role) relative to the research participants i.e. HCAs. In this study, I am an Area Director for Nursing and Midwifery Planning and Development, Health Service Executive, West of Ireland. In this capacity I have governance over five Centres of Nursing and Midwifery Education (CNMEs), in which the HCAs undertake their training. I also have input into the determination of the numbers of HCAs trained annually on a national basis. This created a significant power relationship issue and was the main focus of the review by the ethics committee in Northumbria University. Consequently, a high degree of sensitivity on my part was required to ensure this relationship did not compromise the participant or the

study in any way. In the first instance, I addressed the power issue by not approaching respondents directly to seek their participation and by facilitating respondents to choose to participate or not and in a way that ensured they did not have to 'say no' to me directly. This was achieved by putting a process in place whereby I had no direct contact with potential respondents until after they had volunteered. The recruitment of the participants for the focus groups was undertaken by the local Centres of Nursing and Midwifery Education (CNMEs) following approval by Directors of Nursing as gatekeepers to access the HCAs in their employment.

The identities of HCAs who chose to participate were revealed to me by the relevant CNMEs only after they had accepted the invitation to participate. I made no effort then or since to identify people who choose not to participate. The focus group process will be further outlined later in this chapter. In summary, every attempt was taken to ensure that ethical considerations were adhered to during the case study period. Attention was given to ensuring participants were aware of the study's purpose to provide consent. As the researcher, I endeavoured to respect the participants and the information they have provided, such that it was handled sensitively and in ways that maintained confidentiality and anonymity.

4.6.7 Sampling

In section 4.6.1 of this chapter, details were outlined on the proposed numbers of participants in both the semi-structured interviews and the focus groups. Establishing the number and profiles of the invited research participants is regarded as an integral part of research design (Parahoo, 1997; Abrams, 2010). This study employed purposive sampling as a means to ensure that all of the key stakeholders that would influence any national decision on the regulation or otherwise of HCAs would be represented. Purposeful sampling is based on the assumptions that a researcher's knowledge about the population can be used to hand pick the cases to be included in the sample (Polit and Hungler, 2001, and cited in Shannon, 2012: 74).

The use of purposive sampling, therefore, is appropriate for this study as it allows for the selection of respondents who are information rich at different levels in the discussion of the proposed regulation of HCAs in Ireland (see Thompson 1999 for a wider discussion).

The sample of participants chosen for this study consisted of individuals who could provide a considered perspective on the issues associated with proposed regulation of HCAs. For the initial focus group phase, thirty-four HCAs were purposively chosen for their experience, qualifications, diverse organisational backgrounds (i.e. public, private and voluntary) and diverse areas of practice (see Table 4-1 below).

Table 4-1 Summary of number of focus group participants

Focus Group Category	HSE	Voluntary	Private	FETAC Qualified	Non-Qualified	Total Target	Total Actual
HSE West including pilot	10	1	2	13 (including 1 with level 6 management)	0	14	13
HSE South	7	0	1	8 (including 1 HCA with phlebotomy)	0	10	8
HSE Dublin	13	0	0	10	3	10	13
Total	30	1	3	31	3	34	34

Furthermore, my sample strategy for the focus groups also ensured that I had a geographical spread of HCA respondents nationally to capture the nuances associated with HCA work across urban and rural locations. I specifically targeted locations where Centres of Nursing and Midwifery Education (CNMEs) existed to enable the recruitment of the HCA respondents and the scheduling of the focus group meetings as outlined in section 4.6.2. I was also keen to recruit HCA respondents with variable lengths of experience and maturity working in the Irish health service that promoted diversity but that also had potential to offer a unique insight into the discussion. See Appendix 9 for the demographic profile of the HCA focus group respondents. Further details of the sampling process are included in section 4.6.8 below.

The in-depth interviews represented the second phase of data collection. Purposeful sampling allowed for the selection of thirteen participants from the following categories of relevant key stakeholders that were considered subjects for the research to be conducted:

1. Policy Makers
2. Senior Service Managers
3. Regulators
4. Educationalists
5. Trade Union leaders
6. Patient Representative Association
7. Nursing Homes Ireland
8. Private Home Care Support Agency

In summary, the sample included Deputy Chief Nursing Officer, Department of Health, Directors of Nursing, Director of Office of Nursing and Midwifery Services, HSE, General Manager of SKILLS Project, INMO and SIPTU trade union leaders, NMBI regulatory board, CNME Director, Service User Representative and Nursing Homes Ireland. The Private Home Care Support Agency was only added to the above key stakeholder list following stage 1 data collection with focus groups as a consequence of concerns expressed in these groups regarding lone workers providing domiciliary care to vulnerable people.

Any national decision on the regulation or otherwise of HCAs will be influenced principally by the members of these categories of stakeholders. For that reason they constituted the most important targets for the primary research conducted as part of this study (see Table 4-2 below)

Table 4-2 Summary of number of participants in interviews

Category	Numbers
Policy Makers	1
Service Managers	4
Educators	1
Trade Union Leaders	2
Regulatory Bodies	1
Service User Representative	1
Nursing Homes Ireland	1
Private Home Care Support Agency	1
Irish Association of Directors of Nursing and Midwifery Representative	1

Total	13
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4.6.8 Inclusion and exclusion Criteria

Inclusion criteria for focus groups were that participants must be employed as HCAs in direct clinical care in the Irish health service and report to a nurse or midwife. The criteria were inclusive of both HCAs who were qualified under QQI (FET) level 5 and those who were not qualified. The sample included representations from the following eight care groups: Mental Health; Intellectual Disabilities; Acute General Hospitals; Older Person Services; Community Services; Primary Care; Public Services; Private Services.

Those excluded from the focus groups included any other equivalent grades such as Home Help staff and HCAs who report into a non-nursing and midwifery structure.

4.6.9 Pre-Test/Pilot Study

A pilot focus group was undertaken with four participants to determine if the interview schedule was clearly worded, free from major bias and whether the participants understood and could fully respond to the questions posed (see Polit and Hungler, 2001).

Transcribing the recorded pilot interview myself allowed me to assess my interview techniques, skills and choice of questions. I also discussed the experience with my supervision team. Consequently, only minor changes to the interview schedule and the interview techniques were made and included making greater use of active listening and introducing a questionnaire to capture the clarity of the responses and the representativeness of the views. The data from this pilot focus group were subsequently used for analysis in the study.

4.6.10 Phase 1 - Focus Groups

The initial exploratory phase was conducted using focus groups (n=3) to better understand the perceptions and experiences of HCAs working in the Irish healthcare system and why the role should or should not be subject to professional regulation in the future. Focus groups are a form of interview technique with small groups of people on a specific topic who interact with each other using group dynamics to stimulate discussion (Patton, 2002). The moderator is required to deliberately attempt to surface the views of each person in the group when discussing in depth specific aspects of the case study (Krueger and Casey,

2014). Therefore, the aim of these focus groups was exploration and clarification of group views to ensure a deeper understanding of HCAs' perspectives of professional regulation in ways that would be less easily achievable in one-to-one interviews.

4.6.11 Preceding the Focus Groups

An interview schedule based on the literature review and on the objectives of this study was developed by the researcher, to ensure that the specific topics of interest to the research study were addressed in the focus group. See Appendix 10 for a copy of the interview schedule. I consulted with my supervision team regarding the content of the interview schedule, to verify the clarity, understanding and sequencing of the questions. Consequently, five key themes as informed by the literature (see Appendix 11) and from my own experience were presented for discussion:

- ♦ The nature of the HCA role;
- ♦ Relationships with other healthcare workers;
- ♦ Risks and patient safety;
- ♦ Access to information;
- ♦ Proposed professional regulation.

Prior to commencing the focus group interviews, participants were given a brief introduction to the concept of professional regulation and its application in the context on this study. This was followed by a detailed explanation of the focus group approach and it was repeated that participation was voluntary and that participants had the express freedom to withdraw at any stage, decline to answer questions or request to have the digital recorder turned off. A consent form (Appendix 12) was also signed by all participants and participants were verbally reassured that the process would remain confidential and their participation would be anonymous.

4.6.12 Facilitating the Focus Groups

Each of the focus groups was facilitated by me in the role of moderator of the discussion. I was also accompanied by a Co-ordinator of HCA training from the relevant Centre of Nursing and Midwifery Education to dilute any sense of power imbalance between me as researcher and the focus group participants. The Co-ordinator also adopted the role of note-taker who commented in writing on the general atmosphere of the session and made any other observations of interest.

The discussions were recorded and each focus group was one hour in duration, with additional time allotted at the beginning of the group to allow for a settling in and familiarisation period. The discussion was conducted with the aid of a focus group interview schedule prepared in advance (Appendix 10). Probing questions were used to follow up on contributions that required further clarification.

Good engagement and communication was observed between the participants in each of the focus groups, as they openly and honestly shared their views. When closing the focus group discussions, I thanked the participants for their contributions and concluded by asking if there were any further questions.

The recorded discussions were transcribed by me and a copy forwarded to each participant for further clarification and comments together with a covering letter (see Appendix 6). When the focus groups had concluded, the participants were given my contact details, if they wished to follow up or discuss any aspects of the study further. The outcomes of this process were cross-referenced with the outcomes of the semi-structured interviews which will be discussed next.

4.6.13 Phase 2 - Semi-structured interviews

The second phase of data collection involved semi-structured interviews with key stakeholders as previously identified in Table 4-2 above. These strategic leaders, policy makers and key informants were both knowledgeable and influential on the concept of professional regulation for HCAs in Ireland.

In accordance with the explorative nature of this case study, the purpose of the interviews was to see and understand the views of the respondents in respect of the research topic. In

that regard, King (1994: 15) recommends that there is ‘...*low degree of structure imposed on the interviewee, a preponderance of open questions, a focus on specific situations and action sequences in the world of the interviewee rather than abstractions and general opinions*’. I employed, therefore, a semi-structured approach to the interviews for the purpose of primary data collection.

4.6.14 Interview Schedule

Consequently, a semi-structured interview schedule was designed to facilitate the gathering of the data using primarily open-ended questions. The nature of the questions to be asked at the interviews was informed by the objectives of the study, the literature review and the emerging themes arising from phase 1 of the study – the focus groups.

A copy of the final schedule is presented in Appendix 13. The schedule addressed the following areas:

1. The nature of the HCA role to include lone worker;
2. Relationships with other healthcare workers;
3. Risks and public safety;
4. Access to Information;
5. Proposed professional regulation.

4.6.15 Conducting the interviews for the case study

I conducted thirteen semi-structured interviews on a face-to-face basis. It was decided that by interviewing a smaller number of participants rather than sending out an anonymised survey with specific questions to answer would yield more in-depth responses which would result in richer data. As the subject of regulation is relatively complex, some of the questions could be open to misinterpretation on a questionnaire. Furthermore, some responses were anticipated to require further probing to elicit more detail and this could not have been achieved through the use of a questionnaire. The interviews commenced

approximately six weeks after the final focus group and took place between October 2015 and March 2016.

As the Area Director of Nursing and Midwifery Planning and Development in the HSE, Ireland, I was professionally acquainted with most of the interviewees and therefore acutely aware of the potential issue of familiarity between me as interviewer and the participants. Krueger and Casey (2014) warn that familiarity can hinder disclosure; therefore to remain focussed, I reiterated the aim and objectives of the study prior to the commencement of the interview.

Contact was made with the interviewee by email or telephone prior to each interview to agree a mutually convenient date and time for the interview to take place. A follow up letter was subsequently sent (Appendix 3) in order to confirm agreement. At all times the scheduling and location of the interviews were directed by the person being interviewed. The letter also included an information sheet on the purpose of the interview (Appendix 5).

Participants were assured of the voluntary nature of their contribution and of the confidentiality of their responses. At the beginning of the interview, the participant was asked to sign a consent form (Appendix 12). The reassurance that the confidentiality of individuals participating in the research study would be maintained was of particular importance owing to the small numbers involved in this phase of the study. Furthermore, the level of seniority of the posts held by some of the interviewees could have resulted in individuals being identifiable in the thesis if due care and attention were not paid to how the data were recorded, stored and reported (Wiles et al., 2006).

The interview schedule described above was used as a format to guide the interviews, which were all digitally recorded for transcribing verbatim by me at a later date. Following this schedule ensured a consistent approach to the themes covered during each interview, whilst enabling me as interviewer to be flexible to explore new lines of inquiry if these arose in the course of discussions. I was acutely aware of the importance not to lead the participant and thus open-ended questions, appropriate probing and active listening skills were used to elicit the experiences, opinions and beliefs of the participant on the subject matter. The use of prompts and probing also determined whether the level of knowledge and understanding of the participant was such as to merit more in-depth exploration of a

particular topic or theme, or whether it was more appropriate to move on to a subject about which they were more informed.

Each of the thirteen interviews varied in length from twenty-eight minutes to forty-five minutes with an additional fifteen minutes allowed for introduction and conclusion. The interviews were conducted in a relaxed and conversational manner, designed to encourage the respondents to express themselves. The overall flow of the interview was encouraged by the use of techniques such as not interrupting, following up on leads and remaining attentive. All of the interviews were digitally recorded and transcribed in full by me, which gave me closeness and an early grasp of the data. I also kept reflective notes of each interview and these served as a summary of the key points discussed.

At the end of the interview session I asked each individual interviewee if there were any other matters they wished to raise which had not been addressed during the interview. A few interviewees raised additional issues including forthcoming policy work or potential subject matter for future reviews, and suggestions for additional contacts. Whilst the suggestions were welcomed, no further stakeholders were added to the research sample as data saturation was occurring.

The participant was also given a contact telephone number should they wish to follow up on their comments or seek additional information on the progress of the research. A copy of the transcribed manuscript of the interview was made available to them.

4.6.16 Documents and Reports

A number of types of archival records and documents may be used to triangulate data within the case study (see Yin, 2003). These included the following that were systematically collected in relation to the question of professional regulation for HCAs in Ireland:

- ♦ Annual Reports from Regulatory Agencies;
- ♦ Survey data to include HCA census records in the HSE;
- ♦ Archival records and minutes of meetings relating to the establishment of the HCA role in Ireland and subsequent training;

- ♦ Formal evaluations of the role of the HCA;
- ♦ Internal proposals relating to governance;
- ♦ Policy documents and partnership agreements between various Governments and Trade Unions.

The most important use of documents and archival records is to triangulate with data from other sources (Yin, 2003). Where they are contradictory rather than corroboratory, further investigation may be prompted.

4.7 Evaluating the Quality of the Case Study Research Design

The use of reliability and validity are common in quantitative research (Golafshani, 2003; King and Horrocks, 2010). In fact, in the absence of reliability and validity criteria Morse et al. (2002) hold that the value of qualitative research is reduced to little more than fictional journalism as it is bereft of the necessary rigour. However, some methodologists argue that the use of such positivist terminology in qualitative research is ‘...*not congruent with or adequate to qualitative work*’ (Ely et al., 1991: 95). Writers such as Lincoln and Guba (1985) reject the labels of reliability and validity and replace them with the more desirable qualitative equivalent of trustworthiness which adhere more to naturalistic research. Trustworthiness refers to the confidence or trust one can have of a study and its findings (Robson, 2011).

One approach for judging the quality of case study research designs is the application of four tests commonly used to establish the trustworthiness of any empirical social research. These are credibility, transferability, dependability and confirmability (Lincoln and Guba, 1985; Polit and Beck, 2013). I have adopted this stance and used these tests to demonstrate trustworthiness in the study findings.

Table 4-3 below presents the four tests together with the associated strategies to meet the requirements of the tests and reference to the phase of the study where the strategy is used. Each of these four tests will be discussed in more detail in the next subsection.

Table 4-3 Design tests and associated case study strategies employed

Tests	Case Study Strategies	Phase of Research in which Strategy Occurs
Credibility	<ul style="list-style-type: none">♦ Use multiple sources of evidence (Triangulation)♦ Member checking♦ Prolonged and in-depth engagement with the data	Data collection Data collection/data analysis Data Collection
Transferability	<ul style="list-style-type: none">♦ Analytical/ theoretical generalisation	Findings and Recommendations
Dependability	<ul style="list-style-type: none">♦ Audit trail/chain of evidence	Data collection/Data analysis
Confirmability	<ul style="list-style-type: none">♦ Reflexivity	Data collection/Data analysis

Adapted from Yin, 2014

4.7.1 Credibility

This test refers to the extent to which there is confidence in the truth and the interpretation of the data (Polit and Beck, 2009). As shown in Table 4-3 above, three strategies are available to increase credibility with regards to this case study.

Triangulation

A particular strength of case study research is that multiple sources of evidence may be collected to explore a phenomenon. This affords the researcher the advantage to develop converging lines of inquiry, or triangulation. Case studies that used '*multiple sources of evidence were rated more highly, in terms of their overall quality, than those that relied on only single sources of information*' (Yin, 2014: 119).

Patton (2002) described four types of triangulation: (a) the use of a variety of data sources (b) the use of multiple methods to examine a research problem (c) the use of multiple perspectives to interpret data and (d) the use of several different researchers. The present discussion pertains only to the first of these four types (data triangulation), encouraging the researcher to collect information from many sources but aimed at corroborating the same findings.

This study draws on data collected from the following sources; Focus groups, in-depth interviews and document analysis. Triangulation, therefore, offers the opportunity for exploring multiple views within this case study. For example, the perceptions of HCAs were compared with the responses from the senior managers and policy makers. Further HCAs' perceptions on preparedness to pay for professional regulation were weighed against financial reports on the cost of administering regulatory functions.

It is likely, therefore, that both consistency and discrepancy emerges from this cross checking of data. Also, where there is uniformity in the data from two or more sources then, to some extent, they cross validate each other; and where there are inconsistencies, further investigation may be required to explain the phenomenon of interest (Robson, 2011).

Member Checking

The second principle to increase the credibility of the data in a case study is the process of verifying data and comments on interpretation with study participants (Sandelowski, 1986). This strategy is critical to enhancing credibility and was addressed by presenting a sample of the respondents with the findings of the study and asked to comment on the accuracy and trustworthiness of the results (see Appendix 14). A related strategy to enhance credibility, and therefore a way of improving the quality of case studies, is to have 'draft' transcripts of focus groups and in-depth interviews reviewed by those who have been the subject of study (Yin, 2003). All participants were given the opportunity to review the transcripts from their own focus group or interview for validation of accuracy of their discussions. This procedure has strengthened the corroboration of the essential facts and evidence presented in this case report.

Prolonged and in-depth engagement with the phenomenon and data

Another strategy to establish credibility in qualitative research is the extent to which the researcher engages with the data and the respondents to gain a deep understanding of the phenomenon being studied. In this case study data collection took place over two phases lasting eleven months enabling an ongoing process of analysis and constant comparison of the data.

4.7.2 Transferability

This second test refers to the ‘...*extent to which the findings can be transferred to other settings or groups*’ (Polit and Hungler, 1999: 717). I will seek to make generalisations, but these will largely be in relation to events and issues within the case itself, relative to the future of the case and new situations that may arise (Stake, 2003). Furthermore, Stake (1998) refers to the use of thick descriptions in a case study, which may enable the findings of the study to have resonance with the reader and to establish the degree to which the findings may have application to their own context. This transferability to other settings is also referred to as analytical or theoretical generalization (Robson, 2011). There will be no attempt to generalise to populations beyond this study.

4.7.3 Dependability

The objective of the dependability test is to demonstrate that the case study procedures can be repeated by future researchers (Lincoln and Guba, 1985).

Audit Trail

The critical principle to increase the dependability of the data in a case study is to maintain a chain of evidence or an audit trail. Such a principle is based on the notion that the researcher should have a detailed audit trail to allow another researcher or external observer to follow the derivation of any evidence from initial research objectives to ultimate case study conclusions (Yin, 2014). More importantly, it allows an external observer to challenge or confirm the interpretation of the data made by the researcher. All research, regardless of underlying philosophy, should be auditable, open and transparent.

Readers should not be left in the dark in relation to any aspect of the research process (O’Leary, 2004). A detailed audit trail was therefore maintained throughout the research, heightening the overall quality of this case study. The audit trail for this study includes:

- ♦ All preparatory documentation, including research proposal, discussions and correspondence regarding proposals, correspondence with ethics committees, approval notifications;

- ♦ All documentation related to recruitment of participants for primary research (letters of invitation, information sheets, signed consent forms) (Appendices 2, 3, 4, 5 and 12);
- ♦ Raw data (transcripts of interviews and focus group notes taken etc.);
- ♦ Record of participant validation of transcripts following interviews and focus groups, including letters to participants and responses;
- ♦ Details of the coding and data analysis (including hand marked transcripts and revised coded transcripts following on reflection);
- ♦ List of Documents and Financial reports analysed in respect of regulation functions and costs.

The study's data collection procedures are described in detail, thereby facilitating transparency. Furthermore, the primary data are presented in the thesis in the form of written quotations and extracts from the focus groups and interviews to support and exemplify the richness of the data.

Research supervision for this case study has meant that work has not been undertaken in isolation but was open to review and questioning of decisions regularly by the supervisory team. Moreover, peers and other academic supervisors at the compulsory Annual Faculty Research and Doctoral Conferences as well as the Turkey research summer school provided constructive feedback to me in respect of the study.

4.7.4 Confirmability

This fourth test refers to the extent to which the findings reflect the focus of the enquiry (Lincoln and Guba, 1985) and not the bias and personal values of the researcher (Bryman, 2012).

Reflexivity

Confirmability is enhanced by the use of reflexivity. According to Parahoo (2014: 253) *'Reflexivity is the act of examining one's own assumptions, prejudices and decisions to find*

out how these may have affected data collection, analysis and interpretation'. During the study, I endeavoured to use methods that facilitated reflexivity. Therefore, to ensure credibility of findings situated in this thesis, an account is provided in the ethics section 4.6.4 of the researcher's professional status, and the possible effects this may have had on data collection. In addition, I have kept reflective research notes during data collection and analysis to record my reactions to events occurring throughout the research process. Where relevant, these reflections are incorporated, presented, and highlighted as part of the analysis. A personal reflection on the doctoral journey is also offered in the conclusion chapter. In doing so, these strategies provide an opportunity for the reader to judge any possible bias the researcher may have introduced throughout the study.

4.8 Analysis of the Data

This study involved data collection and analysis initially in two distinct but sequential stages as follows:

Stage 1 - Employed focus groups to better understand the perceptions and experiences of HCAs working in the Irish healthcare system and why the role should or should not be subject to regulation in the future. The data collected and analysed for this stage were used to generate the questions for stage 2 of the study - semi-structured in-depth interviews with senior key stakeholders. O'Leary (2004: 195) defined qualitative data analysis as follows:

In qualitative analysis understandings are built by a process of uncovering and discovering themes that run through the raw data, and by interpreting the implication of those themes for the research questions. In qualitative analysis coding such themes is not preliminary to any analysis but is part and parcel of interpretative practice itself.

In order to gain an understanding of the focus group participants' and interviewees' perspectives of HCAs working in the Irish healthcare system and why the role should or should not be subject to regulation in the future, the tape recordings and transcripts were analysed from both stages. Kvale and Brinkman (2009: 190) hold that '*...the ideal interview is already analysed by the time the sound recording is turned off*', highlighting the importance of active listening, timely interpretation and understanding of the participant's responses during the interview on the part of the researcher. Therefore, data analysis was ongoing during the focus group discussions and the in-depth interviews. The

transcribing commenced immediately after the focus groups and interviews, allowing for data collection and data analysis to occur simultaneously.

I removed all identifying information from the transcript and sent a copy of the transcript to each participant and interviewee inviting them to remove any further identifying data that may have been overlooked by me. The transcript was then analysed by me.

The process of analysis required me to become deeply immersed in the qualitative data (Byrne, 2001; Green et al., 2007).

Following the initial sequential data analysis to inform the interview schedule design for the semi-structured interviews, the analysis of this case study became increasingly iterative in nature. The use of multiple methods of data collection within the case study approach and triangulation of data sets meant that some analyses had to be revisited as new data were produced. Therefore, I undertook repeated readings of interview transcripts, together with recurring listening to digitally recorded data, to construct meaning from the large volumes of data.

4.8.1 Analytical Method

In this case study, the focus group data and in-depth interview data were subjected to template analysis. King, (2012: 426) describes a template analysis as *‘a style of thematic analysis that balances a relatively high degree of structure in the process of analysing textual data with flexibility to adapt it to the needs of a particular study’*.

Central to the technique is the use of a coding template which is produced by an initial thematic coding of a subset of the data. The initial template is then applied to the next data subset and further revised and refined, i.e. new themes added and modified as necessary. The template is then used to code the whole of the data set in an iterative process of applying, modifying and re-applying the template. The final coding template can be employed as a basis for the presentation of an account of the interpretation of the results (King, 2012).

4.8.2 Reasons for selecting Template Analysis for this Study

Template analysis was selected for this case study over other forms of thematic analysis for the following six key reasons:

1. Template analysis is not married to any particular epistemology; rather, it can be employed to analyse textual data from a range of methodological and epistemological positions (Waring & Wainwright, 2008). It is not therefore inconsistent with the social constructionist position of this particular study (King, 2012);
2. Secondly, template analysis is generally less time consuming and can handle larger data sets rather more comfortably than other forms of qualitative analysis. As this research includes datasets from four focus groups encompassing 34 participants and a further 13 in-depth interviews, it was my position that this technique lent itself well to this type of analysis;
3. A key characteristic of template analysis is the use of *a priori* themes i.e. the freedom of the researcher to identify some themes in advance arising from previous research and literature that are strongly expected to be relevant to the research. This does not preclude the emergence of new themes from the analysis of the data or even the redefining or discarding of established *a priori* themes. It was pragmatic to adopt a method for this study whereby broad themes identified in the literature together with themes determined by my research objectives e.g. public safety could be accommodated in the data analysis;
4. Template analysis emphasises hierarchical organisation of codes with clusters of similar codes leading to the emergence of higher order codes. King (2012: 431) proposes that this technique '*allows the researcher to analyse texts at varying levels of specificity and there can be as many levels of themes as the researcher finds useful*'. The flexibility to develop levels of themes and categories as a means of gaining greater insight into this research is in keeping with the case study approach outlined in section 4.5 i.e. to generate an in-depth understanding of the requirement or otherwise for the regulation of HCAs. As well as developing links

hierarchically between themes, the template also allows for the presentation of lateral relationships between themes;

5. Template analysis is a highly flexible approach that allows the researcher to tailor the analysis to the requirements of a particular study (Waring and Wainwright, 2008). The technique allows the researcher to focus on developing themes more extensively where the richest data are found. This is in contrast to other forms of qualitative and thematic analysis whereby the approach is generally more structured requiring the analyst to move from descriptive themes to interpretive themes and then into a few major overarching themes;
6. Finally, template analysis '*works well in studies that seek to examine the perspectives of different groups within an organizational context*' (King, 2012: 447). This research has sought the views of a range of stakeholders in respect of professional regulation as already outlined in Section 4.6.8.

4.8.3 A priori themes

A priori codes for this study included themes identified in the corpus of literature as significant to the subject of professional regulation for HCAs in Ireland. In addition further themes were determined as a priority arising from the aim and objectives of the study. These *a priori* themes were initially selected as a focus for the preliminary template and it was anticipated that these themes would form the higher level codes and that codes emerging from the transcript would form the lower level codes. As the analysis progressed the *a priori* themes could be dropped or hierarchically reorganised with each application of the coding template to a dataset.

4.8.4 Creating the Template

I transcribed each focus group discussion and interview verbatim, which assisted greatly in becoming immersed in the data. I was also able to reflect on emerging themes, categories, sub-categories and codes whilst transcribing. All transcripts were read in full before the initial stage of the coding. The data from three transcripts were initially analysed by assigning pre-defined codes to themes or generating new codes for themes emerging from the data. The transcripts were coded by highlighting words or sentences that appeared to reflect the relevant content and meaning of those statements:

A code in qualitative inquiry is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data (Saldana 2013: 3).

Furthermore, I also employed in vivo coding that utilises a word or short phrase found in the transcripts (Saldana, 2013).

An initial template was therefore created based on this subset of data and combining *a priori* and emergent codes. Any uncorroborated *a priori* codes were not removed at this initial stage to allow for the alignment of any significant themes that may emerge from subsequent transcripts with these *a priori* codes if appropriate.

Examples of initial codes, sub-categories and categories developed for the theme '*perceptions of the evolving role of the HCA in Ireland*' are provided in Table 4-4 below.

Table 4-4 Initial codes, sub-categories and categories for theme 'Perceptions of the evolving role of the HCA in Ireland'

Theme: Perceptions of the evolving role of the HCA in Ireland		
Level 2 Category	Level 3 Sub-category	Level 4 Codes
Role identity	Sense of worth and value	Sense of powerlessness; resentful workforce; 'treated as a grunt'; feeling undervalued; disheartenment within the role; unrewarded; underpaid; 'I love my role'; no recognition; sense of appreciation from patients; degradation of the role; disregard or rejection of HCA knowledge; value of role/experience; felt controlled by the dominant profession (nurses); unequal opportunities for HCAs; 'not paid to think'; manual/hands on value only.
	Visibility of the role	Mistaken identity; unseen work; disregard or rejection of HCA role; mistaken for other professionals; confused public; lack of unified voice; directionless group; sense of desire to take control of own

		destiny; lack of group cohesion.
	Frontline Care	Ever present; gatekeeper role; sense of appreciation from patients; passionate about the role; importance of the role to the patient; claims that HCA is more approachable than the nurse; 'care assistants doing the bulk of patient care'; nurses increasingly distant from bedside.
	Uniform and Job Description	Desire for a national uniform; national job description; job description does not reflect additional skills and responsibilities; unclear or uncertain roles.
Role parameters	Scope of Practice	Working beyond competence; acutely aware of parameters of the role; self awareness of limitations of own scope of practice.
	Use of HCA Skills	Optimum use of skills; under use; HCAs prevented from using their skills; variable experiences.
	Exploitation	Underpaid; dirty work; unwanted tasks; migrant workers.
	Supervision	Unsupervised; lone worker; role delegation; experienced nurses more confident at delegating advanced tasks.
Role boundaries	Blurred boundaries	Accountability; undergraduate nurse training; variability; mistaken identities; HCAs being asked questions more appropriate for doctors and nurses; sense that the job is vague, very broad and open to exploitation, HCAs and MTAs; sense of confusion regarding roles and diversity of titles.
	Exclusionary tactics	Handovers; patient information; delegation; nurses not sharing information; delegating unwanted tasks; HCAs prevented from using their skills; sense of frustration on HCAs at not being allowed to use transferrable skills, 'you are not a nurse'.

Career	Stop Gap	Not a career; 'just a HCA',
	Desire as a career choice	Desire to promote the role; no barriers to entry; motivated by quick money and not for patient care; no interest in nursing career pathway.

Some codes might have been inserted into more than one category initially. For example, 'mistaken identities' initially emerges in separate categories for role identity and role boundaries.

The revised template was then applied to the next four transcripts and the same process as outlined above was repeated. This iterative process of applying successive versions of the template to subsets of the data and modifying as necessary continued until all the transcripts were coded. As the template developed through subsequent iterations, the template hierarchy was rearranged to best represent the emergent themes and organise similar themes into clusters, thereby beginning to define the nature of the relationships within and between these groupings. This included the emergence of hierarchical relationships within themes as well as lateral relationships across clusters. For example, the template development process also uncovered several integrative categories which permeate many of the main themes (King, 2012). These include 'lone worker', 'just a HCA', 'variable practices' and 'restricted supervision'. In total, five iterations of the template were created before settling on the final template as follows:

Table 4-5 Template development

Template Sequence	Number of Transcripts Applied
Initial Template (1)	3 Transcripts
Second Template	4 Transcripts
Third Template	3 Transcripts
Fourth Template	3 Transcripts
Fifth Template	4 Transcripts

After the final transcript was analysed, *a priori* codes that did not have data to support them were removed and the template was again revised. The final template was then used to recode all the transcripts. A full worked example of the evolution of theme "*Perceived*

value of professional regulation for HCAs and the public” over the course of the analysis is presented in Appendix 15. The findings from this analysis are presented in the next chapter.

Overall, I would conclude that Template Analysis is a clear and flexible approach with real utility in qualitative research. The coding structure allows for flexibility to explore in depth important aspects of data consistent with the requirements of this case study approach. The principles of the method are easily grasped, the use of a preliminary template followed by the cyclical process of coding means that the approach can be less time-consuming than other methods of qualitative data analysis. The significance of the flexibility to modify each iteration of the template lends itself well to this study and allows for the careful consideration of how themes relate to one another.

4.9 Summary of the chapter

This chapter has provided my methodological framework including outlining the appropriate data sources required to explore my research objectives and best suited to my epistemological orientation and the implications that this has on the methodology that I have chosen. I have also given a detailed overview of the theoretical and practical implications of my chosen research methods and the sampling strategy that was used.

Furthermore, I have also attempted to address some of the concerns that are often associated with qualitative research and, in particular, the case study approach. I have also discussed some of the potential ethical issues, which were present in the research and how I have managed these. The chapter concluded with reference to the method of analysis adopted and my rationale. The findings are discussed in the following chapter.

Chapter 5 Presentation of Findings

5.1 Introduction

Having analysed the data using Template Analysis, this chapter provides a full account of the outcomes of this process and presents the findings using the five top level themes identified;

1. Perceptions on the evolving role of the healthcare assistant (HCA) in Ireland;
2. Preparation for the HCA role;
3. The impact of the role on quality and patient safety;
4. Opinions on HCAs accessing patient information;
5. Perceived value of professional regulation for HCAs and the public

Each theme consists of sub-themes and lower level coding which represent participants' perspectives of the role of the HCA in Ireland and any future provision for the professional regulation of this occupational group. Whilst the findings are presented as five discrete sections, it is important to note that these findings are fluid and interrelated and as such will be brought together in a broader discussion of the main findings in relation to the literature that is presented in chapter six. See Figure 5-1 below.

As was set out in the case study methodology chapter, data were collected through a range of qualitative methods. Throughout the chapter data collected from these methods will be presented by quoting liberally to support or contradict the contentions being made thereby evidencing 'triangulation' of research data, as an effective method of analysis and interpretation.

I have therefore incorporated narrative comments and verbatim accounts directly from participants in order to retain a sense of realism within the findings and to further illuminate the themes. All the extracts can be traced back to the original transcript source through the index code which is associated with the corresponding narrative extract(s), for

example HCA1FGS refers to Healthcare Assistant 1 Focus Group South or KSH1 refers to key stakeholder 1 in respect of in-depth interviews. Each index code is accompanied by the transcript line number.

Figure 5-1 Research Findings



5.2 Theme One: Perceptions on the Evolving Role of the HCA in Ireland

This theme emerged from the data during the initial phase of data collection and analysis. The primary focus of the HCA role in Ireland is to assist with the provision of health and social care. When the role originally emerged in early 2000, the HCA primarily engaged in

low level non-clinical work such as domestic, catering and portering duties. Participant accounts from both HCAs and key stakeholders referred to the changing emphasis of the role from non-clinical to clinical responsibilities with an increasing contribution towards front line patient care. The theme is composed of three categories called, evolving responsibilities and work practices of HCAs, just a healthcare assistant and role boundaries. Within these three categories are seven sub-categories and all the categories and sub-categories are represented in Table 5-1 below.

Table 5-1 Perceptions on the evolving role of the HCA in Ireland

Themes (Level 1)	Categories (Level 2)	Sub-categories (Level 3)
Perceptions on the evolving role of the HCA in Ireland	Evolving responsibilities and work practices of HCAs	Responsibility Work practices Frontline care
	Just a Healthcare Assistant	Sense of worth and value
	Role boundaries	Scope of practice Use of HCA skills Clarity of Boundaries

5.2.1 Evolving Responsibilities and Work Practices of HCAs

This category will examine the extent to which responsibilities and work practices of HCAs have evolved and the subsequent reliance upon HCAs to increasingly deliver front line care. This category is made up of three related sub-categories; ‘*responsibility*’, ‘*work practices*’ and ‘*frontline care*’.

5.2.1.1 Responsibility

From the findings there was a real sense that HCAs were working with increasing levels of responsibility, and frequently going well beyond the delivery of essential care. As one HCA stated:

My role has evolved where I am in a department now where there was a clinical nurse manager and when he retired I was put into a role alongside another healthcare assistant so we don't have a clinical nurse manager anymore, so my role

now involves an awful lot more of finance, planning and organising outings so my role has definitely evolved since I started. (HCA3FGE; L 35-41)

The responsibilities of departmental budgeting and planning are not included in the HCA job description or in the HCA QQI (FET) Level 5 training programme. Clearly, this HCA was working beyond the scope of their responsibility being expected to undertake managerial functions that were previously the remit of a middle manager. HCAs revealed that staffing levels and skill mix influenced their work practices and subsequent levels of responsibility. Thus, when there were insufficient staff available, the HCAs felt increased responsibility and abandonment in their role whilst also reporting incidents of missed or unmet care:

Like there is much more responsibility on our shoulders you know, as HCA6 was saying you are more one to one with the patient, and there is a lot of the times a huge shortage of staff so you normally obey the rules and regulations, but everything has to be carried out, but half the time it is not carried out properly you know. (HCA8FGE; L88-92)

This notion of increased workload together with reduced staffing levels resulting in missed care or essential care left undone is congruent with other commentators such as Ball et al. (2014) and Wells and White (2014).

HCA participants offered a number of accounts of how the role has evolved in terms of expanding responsibilities. However, early in the research it became clear that this evolution was both patchy and context specific, largely due to variable work based cultures and leadership styles locally. A common concern raised by both HCAs and senior managers was the influence of the nurse on the developing role. One senior nurse manager commented:

I do know some of them (HCAs) are more advanced and they do the observation, dressings, cannulations, ECGs, other kind of advanced skills for their level, but that is dependent on the organisation and the culture and I suppose the views of the nurses to allow that expansion of their role. (KSH1; L31-35)

The inconsistency in the evolution of the responsibilities of the HCA creates confusion within teams and this pattern was perceived by senior managers and HCAs as having implications for quality and patient safety.

5.2.1.2 Work Practices

Alongside the increasing responsibility experienced by HCAs since the emergence of the role, respondents also reported variability in work practices. Whilst this is not an unexpected finding due to the historically uneven introduction of the HCA qualification by health care organisations together with the varying levels of experience in front line care, it nevertheless raises concerns about standards and quality of care provided. HCA and senior management participants acknowledged that essential care activities, such as nutrition, support with dressing, washing, hygiene and mobilisation were fundamental to the HCA role and applied relatively consistently across the Irish health service. It was however the inconsistent recognition for the utilisation of clinical measurement and clinical observation skills that was a source of frustration for HCAs. These skills were not always transferrable from one health care service to the other as described by this HCA:

When I was in (name of Agency) and worked down in (name of service), HCAs were expected to do the obs, blood sugars and swabs, but here they wouldn't let you go near it, they wouldn't actually let you, but elsewhere you are expected to do it as it's part and parcel of your day's work. (HCA10FGE; L119-123)

A contributing factor to the disparity in work practices as revealed by research participants is the broad scope and vagueness of the HCA role that lends itself to misinterpretation and at times abuse by professional staff in the assignment of duties:

The area that I work in is so diverse it's unbelievable, one minute you are wiping the floors and changing the bags and the next thing a nurse could ask you to be sterile and open some packs or whatever, you know what I mean, they wouldn't ask everyone to do that. (HCA2FGP; L290-293)

This apparent overlap between domestic duties involving potential sources of contamination and those clinical practices that require hygiene and sterility is inconsistent with best practices associated with the prevention and control of healthcare associated infections. The HCA has also expressed a sense of inequity and injustice in that no other

group of staff would be expected to undertake such diverse roles and thus reinforcing the notion that the role is less significant than other healthcare occupational groups.

5.2.1.3 Front Line Care

HCA participants repeatedly alluded to the unique qualities that they possessed to deliver effective patient care such as caring attitude, ability to engage with patients, proximity to the point of care delivery and personal life experiences. In contrast, registered nurses were viewed as being preoccupied with bureaucratic and administrative functions, having only passing contact with patients and thereby creating the space for the HCA to become the predominant front line carer:

Sometimes you might know more about the patient than the nurse because you're in the base camp. It's you who is seeing the patient and the nurses are under so much pressure. I've worked in places where there are 63 residents, there's maybe only 4 nurses you know and they're having to distribute or administer medicines, do writing up and you're the one who goes in and sees that somebody's not well. (HCA5FGW; L 106-112).

This sentiment found congruence with senior managers who acknowledged the changing role of the nurse citing additional administrative obligations associated with regulatory bodies such as HIQA. This greater proximity of the HCA to the patient afforded them the opportunity to actively engage, develop trusting therapeutic relationships and become the primary point of accessibility to the patient and the public. The extract below from one senior manager clearly symbolises how the balance of influence has shifted from the nurse to the HCA and the subsequent value that is now placed on the HCA as a front line staff member:

I was in one particular area ... looked around and observed and all the clients were going to the health care assistants. They were like the mothers, the sisters, the family and you could see it and that was only one observation in one very busy general ward. (KSH13; L 334-338)

Whilst HCAs welcomed and valued their responsibilities associated with direct patient care, they nevertheless continued to question the diminishing contribution of nurses to this aspect of care. Some expressed resentment towards nurses and their increasing

administrative responsibilities interpreting it as a means of avoiding the genuine nursing work. Others articulated a sense of mystery and obscurity in relation to the changing focus of the nurse's work and the requirement to be increasingly office bound.

There is consensus in the findings that the HCAs are gaining increasing prominence in the delivery of frontline care in Ireland assisted in no small way by the growing distance between the nurse and the patient. This had bred some discontent amongst HCA focus group participants, occasionally viewing themselves as 'a pair of legs', or 'front line cannon fodder'.

5.2.2 Just a Healthcare Assistant

The category 'Just a Healthcare Assistant' emerged organically from the data as an in vivo code. Such was the frequency of the term used by HCA and key stakeholder participants as well as its application to a wide variety of circumstances and experiences, I decided to elevate it to a category as opposed to retaining it as a lower level code. 'Just a healthcare assistant' represents the views of the research participants in respect of the recognition and value placed on the evolving role of the HCA in Ireland. The category and related sub-category '*sense of worth and value*' is represented in Table 5-1.

5.2.2.1 Sense of Worth and Value

HCA participants expressed a conviction that they were providing an important and highly significant service at the direct point of care to service users across hospital, community and primary care. This was emphasised in their constant referral to the growing reliance on the HCA role.

However, there is an overwhelming sense from the data that non-recognition and a lack of value placed on their role was an issue for HCAs. This non-recognition was presented in different forms. Some questioned why they were not "trained properly years ago". Others feared that they will be left behind as their nursing colleagues forge ahead with their own careers. Some participants recognised the significance of the role but suggested that they remained subservient and beholden to nursing.

One HCA participant described how they are perceived by registered nurses as little more than cheap labour and was rarely encouraged to contribute their opinion or input to discussions on patient care which was evidently a source of frustration:

At the moment we don't have any real accountability to anyone and to be honest we are only paid from the neck down, we are not even paid to think, or instructed to think and I think that would be good for the patients if we were accountable and responsible for our roles. (HCA4FGP; L171-174)

Both HCA and key stakeholder participants observed that the proximity of the role of the HCA is now much closer to the patient both in hospital and primary care. This closer proximity of the HCA to the patient afforded them the opportunity to develop stronger relationships, engage regularly in interactions and observe patient behaviour. Through these interactions HCAs develop a level of clinical intelligence on individual patients, enabling them to contribute meaningfully to clinical discussions. It is therefore frustrating for HCAs and has direct implications for quality and patient safety if clinicians are not considering the opinion or input of HCAs.

Senior managers concurred with the sentiment expressed by the HCAs but cautioned that the feelings of non-recognition and being undervalued were not universally experienced by HCAs across the Irish healthcare system. Many key stakeholder interviewees described these experiences as 'patchy' and 'variable'. The senior manager participants offered a number of possible explanations for these expressions of disheartenment from HCAs which included the physical demands of the role, consequences of austerity since 2008, depleted supervision levels and restricted opportunities for continuous professional development. Some participants including a trade union leader and senior healthcare manager observed it is not only HCAs who feel this way, that from policy level to operational level, no employee has felt valued in the Irish health service in recent years due to poor publicity, high profile scandals and relentless cuts to budgets and staffing.

5.2.3 Role Boundaries

This category relates to the extent that HCA skills are appropriately utilised within the boundaries of the role. It also examines the degree to which the boundaries exhibit blurring or clarity between HCAs and other professional groups such as registered nurses etc. The

findings are presented under the following three sub-categories; '*scope of practice*', '*use of HCA skills*' and '*clarity of boundaries*'.

5.2.3.1 Scope of Practice

The Nursing and Midwifery Board of Ireland defines scope of practice as 'the range of roles, functions, responsibilities and activities which a registered nurse or registered midwife is educated, competent and has authority to perform' (NMBI, 2015:3). This definition has been adopted to demonstrate the extent to which HCAs function within the parameters of their role and responsibilities.

The literature suggests that the growth and evolution of the role of HCA, without clear boundaries, regulation and training, raises concerns over patient safety (see for example Francis and Humphreys, 1999; McKenna et al, 2004; Queensland Nurses Union, 2011). Therefore, it is critical for HCAs as for any other occupational health group to work safely within their scope of practice or competence. It is also of equal importance when considering opportunities for expanding the scope of HCAs in the future; it is done so in the best interest of the patient and the public at large.

The findings provide evidence that HCAs are expected to work beyond their defined scope of practice in support of registered nurses. As such, there is a sense that there is an over-reliance on the role. Incidents of HCAs working beyond their boundaries of practice usually occurred in the context of staff shortages and increasing workload pressures:

It's so busy over there, understaffed, you know, you might go up to a ward, they're down two staff nurses. You'll do the blood sugars there. And you hate refusing, I know technically now we're not supposed to but you try and help give them as much support as you can. (HCA2FGS; L22-26)

In the above situation, the HCA was requested to undertake blood glucose monitoring in the absence of the necessary training for the task and therefore beyond the accepted scope of this HCA's role. There are potential patient safety risks associated with this example and therefore HCAs should not be requested to perform tasks without the necessary preparation and supervision regardless of workload pressures and staff deficits.

Senior managers were not surprised by claims from HCAs that there was this inappropriate reliance on their skills. In fact, the economic crash in 2008 with the resultant cut back in resources and non replacement of registered nurses appeared to legitimise the misuse of HCAs in the Irish health service. This senior manager participant strongly suspects HCAs are being requested to work beyond the boundaries of their role in the interest of patient care:

I imagine, coming out of a recession, there were vacancies, there were people not recruited, very experienced nurses and midwives left the system... So you think of the ED department, I am sure there are healthcare assistants working in EDs right around the country who are doing interventions that are not within their job description, because there are patients there with a need and there are no nurses to look after everyone. (KSH1; L113-120)

Although other reported experiences of being involved in advanced tasks such as medicine administration, running clinics and liaising with doctors were reported by HCAs, it should not be overstated as the majority of HCAs interviewed revealed that they were practicing within their scope of competency. Nevertheless, these examples indicate that the role continues to evolve and HCAs do more than just assist registered nurses.

5.2.3.2 Use of HCA Skills

In contrast to the concerns relating to the over-extension of the HCA role as outlined above, HCA participants also revealed experiences of under-utilisation of their skills which was a source of frustration. This primarily took the form of restriction from involvement in technical aspects of direct patient care for which they were trained and considered competent such as, clinical observations, PEG tube management and wound care. Some expressed sentiments of bewilderment that public monies would be invested to develop the skills base of HCAs, only to be prevented from using those same skills in practice.

One of the things that I said to my manager was that I felt from an employer's perspective surely they are looking at all of us 12 or 13 HCAs, OK we have invested this amount of time and money and effort in you to get you this level of HCA FETAC level 5 and then all of a sudden we are not practicing. (HCA3FGP; L 62-66)

It was perceived by HCAs that a culture of control existed in some services whereby the ways in which HCAs were used or under-used in practice were dictated by registered nurses. This theme found congruence among HCAs and senior managers and there was a shared perception that HCAs were not permitted by qualified nurses to work to their optimum skill level. One senior manager in education expressed a sense of exasperation that time invested in training HCAs was wasted as they became de-skilled quickly when they were not authorised to use the newly developed skills back in their local clinical setting:

One of the programmes and it was very popular was the activities of living patient care. They spent a lot of time on the vital signs. A lot of tutorial time went in. They were actually deemed competent at the point they left the centres. They went out to practice, couldn't utilise that skill because there was no policy in place to support it or indeed, may I say, not much encouragement from qualified staff for that matter.
(KSH8; L32-37)

Some senior managers were both critical and bemused by a culture that prevented HCAs from using their full range of clinical competencies in practice. This was perceived as being naive and wasteful, particularly when most clinical locations do not have the luxury of surplus staff. However, some HCAs also reported positive experiences whereby they felt their newly acquired skills following training were being optimised within the workplace arena. Nevertheless, these experiences were sparse and varied as both HCAs and senior managers agreed that variability in the effective utilisation of HCA skills frequently occurs between different clinical locations and occasionally within the same clinical location.

5.2.4 Clarity of Boundaries

HCAs in this study have repeatedly made reference to 'grey areas' within their role. A contributing factor to this vagueness is the generic nature of the role whereby a HCA could be undertaking direct patient care, cleaning duties, administrative tasks and catering duties, all within the same working day. There is a sense within the data that HCA participants had no common agreement about the HCA role and therefore were unsure of expectations, which resulted in role ambiguity.

Without clear boundaries, there is a perception among other professionals that the role of the HCA and the multitask attendant (MTA) is interchangeable. MTA is a generic support

role with responsibilities for caring, cleaning, catering and portering. Many MTAs have achieved the same qualification as HCAs and provide direct care duties which create a sense of ambiguity between both roles. Several respondents, both HCAs and senior managers, claim that the inconsistent and ‘muddled’ job description that supports the role of the HCA has contributed to the confusion between related roles. On examination of this job description (see Appendix 16) the outline of the role is both vague and nonspecific and does little to negate the variability in the application of the role as reported by the respondents. Furthermore, the senior manager participants reported that the role of the registered nurse has done little to delineate the boundaries between nurses and HCAs. Traditionally, nurses have experienced difficulties in defining their own roles. For example, it was recognised that nurses were adopting additional expanded roles as conceded by doctors, but at the same time continue to undertake basic nursing care roles that should be relinquished to HCAs, with the consequence of overlap in roles between registered nurses and HCAs:

Internationally we still haven’t agreed what a registered nurse is about, so there is huge confusion and there is expansion of our role and extension of our role and yet we still don’t want to let go some of our core roles we’ve had for hundreds of years. So I think it comes down to I suppose maybe a bit of lack of clarity within our own professional relationship what our core role is about. (KSH1; L211-217)

Therefore, the increasing fluidity between the role of the nurse and HCA is partly a consequence of the uncertainty and debate that is ongoing in relation to the role and essence of the nursing profession itself. Senior manager respondents also suggest that blurring of role boundaries have occurred due to a lack of awareness and understanding of the HCA job on the part of the registered nurse. This ambiguous understanding has led to uncertainty of what a HCA can and cannot do with the consequence that some registered nurses will continue to perform basic nursing care tasks that could otherwise be delegated appropriately to the qualified HCA.

Nevertheless, many senior managers did suggest that professional boundaries do exist between the roles of the registered nurse and the HCA but they are perhaps implicit and not readily recognisable to other healthcare workers and the general public. They make reference to the visible distinguishing characteristics of the nurse’s role such as medicines management, discharge planning and degree level entry qualification. However, the less

noticeable features of the registered nurses role are those that helped form a clear demarcation between their role and that of the HCA. According to the senior manager respondents these included higher levels of responsibility, accountability and clinical decision making:

Well, firstly a nurse is a registered professional, so she works under a scope of practice, fitness to practice and all those professional obligations that go with that, whereas a healthcare assistant, even though they have a contractual arrangement that they work to a job description, they don't have the risk, the professional risk of been struck off a register in relation to their career. And I do think as in a nurse as in her clinical skills she has more in-depth training in relation to care of a person, and I think that her clinical decision making is the core one. (KSH1; L49-56)

Therefore, the perception of role blurring between the registered nurse and the HCA does exist on the surface with regard to the overlap in technical tasks between both occupational groups. However, demarcation becomes more evident when examining the less visible features of both roles such as accountability, professional judgement and clinical decision making.

5.2.5 Summary of Theme 1

These study findings suggest that the experiences encountered by HCAs in respect of responsibilities and working practices are variable and context specific. Whilst there is evidence to suggest that HCAs are experiencing increasing levels of responsibility with some claiming that they are currently working beyond their parameters of practice, others expressed frustration at the perceived under-utilisation of their skills. There is also an overwhelming sense of non-recognition and a lack of value placed on the HCA role, a perception that finds congruence with senior managers. HCAs place high value on their close proximity to the patient and do not envy the administrative onerous responsibilities associated with nursing. Both HCAs and senior managers identify the blurring of occupational boundaries between nurses and HCAs as an increasingly worrying feature, prompting patient safety concerns. The next theme will now consider the adequateness of the preparation of the HCA for their role.

5.3 Theme Two: Preparation for the Role

This theme reports the views of HCAs and senior managers on the value and efficacy of the preparation for the role of HCA in the Irish health service. The theme contains one category called, education and training. Within this category there are four sub-categories (see Table 5-2 below).

Table 5-2 Preparation for the role

Themes (Level 1)	Categories (Level 2)	Sub-categories (Level 3)
Preparation for the Role.	Education and Training	QQI (FET) Level 5 Theory/Practice divide Opportunities for training Non qualified HCAs

HCAs in Ireland are delivering direct patient care with no statutory duty or policy for them to have any type of qualification or agreed training. The Irish Government introduced the Healthcare Support Certificate training under the umbrella of the Further Education and Training Awards Council (FETAC) and piloted specifically for HCAs in 2001 – 2002 (Flood, 2008). The successful candidates were awarded a level five certificate on the National Framework of Qualifications (NFQ) which is a system of ten levels. This training continues to be delivered today to HCAs albeit in a revised format but with an equivalent award level at QQI (FET) level 5. Yet, there is no mandatory requirement for HCAs to attain any such qualifications. Furthermore, there is little information on the numbers within the public and private sectors of the Irish health service either holding an award or working towards one. Training providers range from Centres of Nursing and Midwifery Education (in-house training departments) within the HSE and HSE funded organisations to Education Training Boards (ETBs) and independent providers.

This section therefore presents the findings derived from my interpretation of the participants' views on the preparation for the role of the HCA in the Irish health service.

5.3.1 Education and Training

The value of the approved HCA training programme, QQI (FET) level 5 is explored together with the HCAs' broader experiences of training from the perspective of both the

HCA's and the senior managers. The category is made up of four related sub-categories; 'QQI (FET) Level 5', 'theory practice divide', 'opportunities for training' and 'non qualified HCA's'.

5.3.1.1 QQI (FET) level 5

From the data collected there is little doubt that the perceived value of the QQI (FET) level 5 training is variable among the respondents with little agreement between HCA's and senior managers. The senior managers in general were enthusiastic about level 5 training offered to HCA's and reported a journey of personal and professional growth on the part of the HCA. One senior HR manager noted this journey with a sense of pride and emotion:

Having gone back a few years' later with the HR hat on, and met some of the people I would have known beforehand, the difference it made to them personally, particularly people that have been out of the education system for a long time. In terms of their confidence and self-esteem was hugely rewarding to be involved in any way with that process. (KSH7: L181-186)

This sentiment found an echo with many other senior manager respondents who revealed outcomes on the part of the HCA's such as enhanced confidence, improved self esteem and developing a sense of collegiality and improved team work. There was, however, a sense of frustration expressed by some managers as they questioned the fitness for purpose of the programme going forward in light of the expanding HCA role and associated evolving responsibilities. The previous theme has highlighted evidence to suggest that HCA's are experiencing increasing levels of responsibility with some claiming that they are currently working beyond their parameters of practice. One manager perceived the existing level 5 programme to be superficial and inappropriate to develop the knowledge base and competencies of the HCA's for the complexities of care they encounter now and in the future and, therefore, progression to level 6 needs to be considered:

...looking at the epidemiology and the demographics, our ageing population, maintaining people at home longer, maintaining people with chronic diseases, under 65s, maintaining children with complex care needs and the utility of care assistants and the importance of them to facilitate that delivery. I think we need to look further than a Level 5, I think we need to start looking at the Level 6. (KSH9; L53-58)

The service user representative was equally discerning regarding the appropriateness of a level 5 qualification for HCAs should they continue to expand their scope of practice and responsibility. Her concern was founded on her own observations of HCA practices when caring for her mother as well as her own experiences of completing QQI (FET) training. She questioned if the existing training was sufficient to equip HCAs with the requisite knowledge, skills and competencies to care for people with “serious conditions” like her mother. The service user’s observations regarding HCA practices will be re-visited in Theme 3.

The QQI (FET) Level 5 training was also criticised by HCA respondents. Some felt that the programme was ‘too easy’ to complete and thus devalued by HCAs and healthcare professionals. One HCA was particularly disparaging of the training programme, claiming that employees from other industries now undertake the training as a fall-back position following the economic crash in 2008:

No, I don't think that FETAC Level 5 is any good at all. It's a waste of time. I would love to know how many people have been handed a FETAC level 5 in the care of the older person since the collapse of the economy... I left the factory, there were 140 of us let go, there was a lot of fellas. I would say 40 of them have it. (HCA4FGW; L443-447)

Further concerns were raised in respect of the discretionary employer enforcement of the nationally agreed training programme for HCAs. The HSE requires that all new HCA recruits must have a relevant certificate in healthcare support at FETAC Level 5 or a minimum of one year’s relevant experience in a healthcare setting. As a consequence there has been an uneven approach by employers in mandating the requirement for HCA training at entry level which has resulted in a mixture of qualified and unqualified HCAs working together with vulnerable patients. This was clearly a source of frustration for both senior managers and HCAs:

I think if anyone is working out there they should have the qualification. I think it should be mandatory. If you're working at that level or any level and working with clients, vulnerable clients, vulnerable patients, you need an educational background and if it's FETAC level 5 for health care assistants everyone should have it. (KSH13; L 193-197)

I think all HCAs should be trained, you know I think that is a big blurring at the moment, that there is a huge percentage of us that have done FETAC and we were pushed to do FETAC which was good, but as well as that you have all these untrained staff. (HCA4FGP; L443-446)

This sub-category was inconclusive on the value of the current QQI (FET) level 5 HCA training as reported by senior managers and HCAs. Whilst there was a general undercurrent of good will and positivity directed towards the programme, there remains, nevertheless, concerns regarding the ability of a level 5 programme to continue to meet the expectations of an evolving and expanding HCA role. A level of convergence did, though, emerge from the data on the requirement for a policy change to mandate and standardise HCA training going forward.

5.3.1.2 Theory practice divide

The type of learning experienced by the HCA on the QQI (FET) level 5 programme is often influenced by the closeness of the teaching of theory in the classroom to its application in clinical practice. According to Bruner (1997), students should be enabled to generalise from theoretical concepts learned to what they will experience later in the ‘lived’ reality of the practice settings. HCA respondents reported several examples of theoretical teachings not reflecting the realities they face in the clinical workplace. The experiences of theory practice gap were more pronounced for those HCAs with no pre-existing clinical experience. For example, one inexperienced HCA felt totally unprepared for the realities of the new role and subsequent concerns for patient care:

The qualifications don’t prepare you for it at all. The first day I walked in I was put sitting with someone with dementia. That was the first time I had ever met anyone with dementia in my life and that’s not fair on me and it’s not fair on the resident either, you know what I mean. That’s ridiculous like. You mean you talk about it in a classroom setting and then are sent out to do a job, that’s .. it can’t work like that. That’s not a qualification, that’s just people ticking boxes. (HCA4FGW: L 524-529)

The experience of disconnect between learning and clinical practice was felt less acutely by the more established HCAs. There is a sense that undertaking the course is more

relevant and valuable while in clinical practice for those HCAs who are familiar with the care settings. One HCA made the distinction between her experience as an established HCA and her sister who undertook the QQI (FET) level 5 as a novice practitioner:

My sister is doing the course now and just between, I suppose, MRSA and things like that, on paper she can't understand it but I came from being an attendant in the setting to a care assistant, that I'd be like "why can't you pick it up?" But I think when you're doing the stuff you pick it up a lot easier. (HCA6FGS: L552-555)

In concurrence with these observations other HCA respondents suggested alterations to educational preparation with a more balanced mix of theoretical input and practical clinical exposure. However this did not mean that acquiring theoretical perspectives was unimportant and many trainees felt that it was still significant to their learning. One senior manager recalls instances of employing HCAs with qualifications but no prior experience and suggests that regulation is required to correct this theory - practice gap:

But I have experienced in that past, people coming in that have done the theoretical side of it but they don't have any practical experience. Now, I think that needs to be regulated better and it has to be certified and it has to be more evidence-based in terms of what they're doing. (KSH12; L112-115)

The theory - practice divide is therefore a reality for many HCAs in respect of their training and the impact is more acutely felt by participants who had no previous care experience.

5.3.1.3 Opportunities for Training

The overall consensus from HCA respondents was that there were very few relevant courses or further training opportunities offered to them with the exception of the QQI (FET) level 5 training. Furthermore, assistants perceived that no dedicated study time was available to them to facilitate engagement with continuous professional development post their QQI (FET) level 5 qualifications. On the occasion where study time was offered, it was often sporadic and dependent on staffing levels and the workload of the department. There was also a sense of inconsistency in support offered to HCAs for training between different organisations. One HCA expressed a sense of exasperation as she continues to

seek support for a developmental programme that would be beneficial to new mothers in a busy maternity unit:

In my area I have been looking to do the breast feeding class for years because there is a lot of breast feeding about and with working in maternity and I am in the midwifery department for 11 years.... I think it's essential that I do it really and I have spoken to the breast feeding consultant and 'oh we'll do' and it's never happened, other things took priority. (HCA3FGW; L 422-429)

The majority of assistants communicated that they would enjoy not only more training on practical skills but would like a more in-depth theoretical background to training which in turn would improve their input and subsequent patient care. Some HCAs reported that they had taken the initiative to invest in their own personal and professional development rather than waiting for support from their organisation. The following assistant reported that she would not have the required competencies and knowledge for the role unless she had supported herself with training:

I feel I am only trained to what I do because I've gone to seek that training myself, because I think there is an awful lot that's gone into my role that I wasn't given adequate training for unless I done it myself. (HCA7FGE; L486-489)

Senior managers concurred with the sentiments expressed by HCAs and recognised the requirement for a supportive educational pathway for HCAs to follow on from the existing QQI (FET) level 5 qualification. One senior manager referred to level 5 training as 'the floor' and any subsequent training should aim to elevate HCAs to a higher level of knowledge and competency. However, there was recognition that unlike registered nurses and other professional grades, there was no obligation on either the unregulated HCA or the employing organisation to ensure the competencies and skills of assistant staff are regularly refreshed and updated:

There's no obligation, as I understand it, that a healthcare assistant who is doing a fair amount of responsible duties is obliged to have mandatory training every year or upgrade themselves, that's not a requirement. We don't accept it in the Nursing profession. We don't accept it with people working in the Ambulance Service. So why should we accept it with this particular group? (KSH11; L 136-141)

Both HCAs and senior managers point to a restrictive learning environment where there is little evidence of supported access to further training opportunities for assistant staff.

5.3.1.4 Non Qualified HCAs

A failure in policy to mandate the QQI (FET) level 5 training for all HCAs in the Irish health service has resulted in the emergence of a three-tiered HCA workforce – qualified, partially qualified and non qualified. Both HCAs and senior managers point to varying unintended consequences of this arrangement. Qualified HCAs articulated a sense of frustration with the lack of incentives offered by employers on completion of the required training. They were particularly exercised on the subject of remuneration as there is no differential in pay between qualified and non-qualified HCAs. This has led the HCA below to question his own motivation for undertaking the training:

If you have done your FETAC course and your colleague hasn't done a FETAC course, you are both putting in the same effort but you are still getting the same pay and the same recognition. You kind of say after a while well 'why the hell am I bothering to break my back, to kill myself' and just get the same pay as Joe Bloggs whose just walked off the street and hasn't an ounce of training. (HCA10FGE; L969-976)

Senior managers also pointed to concerns with the educational disparity between HCAs but for different reasons. One respondent reported unease among registered nurses who were unclear about the distinction in knowledge and competencies between the qualified and non qualified HCA. This was further blurred if the unqualified HCA had significant pre-existing clinical experience to compensate for the absence of training. Therefore, the hidden disparities in knowledge and skills between qualified and non qualified HCAs posed a risk for the registered nurse regarding the safe and appropriate delegation of tasks. This role confusion has prompted one senior manager to suggest that an awareness raising workshop should be made available to registered nurses to facilitate their understanding on the varying roles, knowledge and competencies of all HCAs:

I think there probably is scope again to re-orientate Nurses and Midwives to the role of the healthcare assistant and I suppose in the difference between the roles of healthcare assistants as well and I think that's particularly important in relation to

FETAC education, those that have and those that don't have FETAC education.

(KSH5; L325-333)

A further concern reported by another senior manager was the challenge to encourage all HCAs under her direct governance to complete the QQI (FET) level 5 training in the interest of quality and patient safety. She acknowledges the nomination and selection process for the training was heavily reliant on the goodwill of the assistant staff and may require a different approach in the future:

It's not yet mandated in black and white for Hospital Managers or Directors of Nursing to say all their healthcare assistants must be fully trained. So we are still operating on a goodwill basis which has been positive, we are getting towards the end of the goodwill spectrum. (KSH7; L135-142)

The three-tiered structure is an unintended consequence of policy at the point of introduction of HCAs to the Irish healthcare system in early 2000. It has presented separate challenges for both HCAs and senior managers.

5.3.2 Summary of Theme 2

Theme two reported on the value and efficacy of the preparation for the role of the HCA in the Irish health service. Whilst a nationally agreed programme exists for training of HCAs, there is no mandatory requirement for HCAs to attain any such qualifications. The perceived value of the qualification is therefore diluted among respondents. In addition, many senior managers questioned the fitness to purpose of the programme going forward in light of the growing role and responsibilities of the HCAs. Both the HCAs and the service user representative were critical of the training for different reasons. Some HCAs were of the opinion that the programme was devalued by its simplicity whilst the service user representative felt that HCAs needed more than a level 5 qualification to care for critically ill people.

HCAs reported a disconnect between class room learning and clinical practice. Furthermore, both HCAs and senior managers point to a restrictive learning environment where there is little evidence of CPD opportunities. Finally, a failure to mandate the QQI (FET) level 5 training for all HCAs in the Irish health service has resulted in the emergence of a three-tiered workforce – qualified, partially qualified and non qualified.

5.4 Theme Three: The Impact of the Role on Quality and Patient Safety

The previous two themes explored in-depth the role of the HCAs in the Irish health service and subsequent preparation for those roles. Those themes unearthed some concerns relating to quality and patient safety with reference to the relevant categories and sub-categories. However, to fully explicate the work of HCAs it is necessary to understand how they perceive the function to impact on the lives of patients together with the forces that influence and shape their role.

This theme focuses on risk associated with the unregulated HCA role and contains four sub-categories (see Table 5-3 below).

Table 5-3 Impact of the role on quality and patient safety

Themes (Level 1)	Categories (Level 2)	Sub-categories (Level 3)
The Impact of the Role on Quality and Patient Safety	Risks associated with the unregulated HCA role	Homecare support services and lone working; Supervision in practice; Delegation; Accountability

5.4.1 Risks associated with the unregulated HCA role:

Recently, due to increasing focus on the quality of health care provided and the move towards person centred care, questions have been raised on the potential evidence for effectiveness of interventions provided by HCAs in health care (Centre for Allied Health Evidence, 2006). The literature would suggest that there is a dearth of strong empirical evidence in support of the extent and nature of the risks presented by the unregulated HCA to the delivery and outcomes of care (Griffiths and Robinson, 2010). This category will illuminate some of the risks to quality and patient safety associated with the unregulated HCA role as reported by the research respondents. The category is composed of four related sub-categories entitled '*homecare support services and lone working*', '*supervision in practice*', '*delegation*' and '*accountability*' as outlined in Table 5-3.

5.4.1.1 Home Care Support Services and Lone Working

Research respondents articulated perceived disparities in standards and practices between home care support agencies with regard to the training and employment of HCAs. Home care is an area of work where a large proportion of staff work alone.

Formal home care services employ HCAs to deliver care to patients in their own homes who need assistance with basic activities of daily living, such as getting in and out of bed, bathing, dressing, eating, etc. Although it is a relatively new sector, this unregulated home care industry has experienced unprecedented growth and has led to significant privatisation of the home care market over the last decade. Furthermore, the demographics in Ireland point to a growing home care support industry with the population of people over 65 growing by approximately 20,000 each year while the over 85 population is growing by 4% annually (HSE, 2015b). The subject of the home care industry drew widespread criticism from respondents for many reasons. The HCA participants were critical of the employment conditions of their colleagues, reporting that they carried an enormous workload, but were paid poorly, suggesting they were the subject of exploitation:

I think that's the worst thing of the lot is the home carers. They're treated like dogs and they're covering a vast circumference and they're trying to look after all these people and they are getting absolutely nothing for it. (HCA7FGW; L1056-1061)

These concerns resonated with senior managers who were not surprised that they were raised during the HCA focus groups. One manager questioned the line of accountability. In contrast to the private residential nursing home sector which is highly regulated by the Health Information and Quality Authority (HIQA), the home care industry remains unregulated in Ireland. For that reason the following senior manager described the concerns raised by the HCAs as legitimate:

I would have a broad concern that the domiciliary care market as it were, the home care, is unregulated entirely you know. The nursing home sector is highly regulated by the other extreme so I think yeah it would be a legitimate enough concern. (KSH4; L300-303)

In concurrence with previous contributors, senior managers were of the opinion that people receiving care at home should not be subjected to lesser standards than patients in hospitals or other healthcare residential environments. To allow the domiciliary care industry to continue to function unregulated is an endorsement of the ongoing exploitation of vulnerable employees:

Until we apply the same standards to providing care in the home to the person, as we strive to apply to care in the institution for that person, then it's always a race to the bottom, and you will get vulnerable people in low level employment, in low pay environments where you know language is a barrier. (KSH6; L341-346)

Moreover, senior managers have revealed that the standards applied to the training of HCAs for the delivery of home care services vary significantly to the standards in place for assistant staff who work in hospitals and healthcare residential services. Currently, these HCA staff complete the full QQI (FET) level 5 training, which is composed of eight modules. This is in contrast to the HCAs employed in the domiciliary care industry who are only expected to complete two of the eight modules. The senior manager below questions their level of preparedness to care for people with complex healthcare needs in their own homes unsupervised:

If I'm looking at the private agencies and they're doing 2 modules of the care assistant course I don't know that that prepares them for the complexity of care that they have to deliver and that they're going to meet both from the patient's point of view and the family point of view and how they're supported in that role. (KSH9; L 133-138)

As the industry grows, there will be an increasing reliance on HCAs to provide care to people in their own homes as lone workers. The notion of unregulated staff with uncertain qualifications and questionable skills sets providing care to vulnerable patients with complex healthcare needs was viewed as a risk to quality and patient safety by senior managers:

What do we know about the professional background in relation to the health care support workers that are going in to provide care to what could be actually our most vulnerable client group? So I do think it is a particular issue and I think in the

absence of regulation and standardisation I don't think we'll ever actually get a handle on that. I do think it is a very real concern. (KSH5; L429-438)

Furthermore, senior managers also viewed the lone working model as having its own unique set of risks both for the employee and the patient. Risks are known to be magnified when procedures are carried out in less controlled settings, such as in patients' homes (O'Shea, 2013). Both parties are being left exposed and vulnerable to varying accusations such as abuse, violence or other forms of criminality. A key concern is the lack of support and supervision available to the lone worker compared to their colleagues working in hospitals and other residential healthcare facilities:

It's knowing where to go, knowing where you can get the answers, knowing that there's someone at the end of the phone that you can rely on if you need to because anyone – whether it be a nurse or a health care assistant – could be very lonely in the community without supports and I don't necessarily believe that those supports are there for healthcare assistants. (KSH13; L160-165)

Home care support agencies are also active employers of migrant workers as HCAs in Ireland and have been heavily criticised for the conditions under which migrant workers are employed (Migrant Rights Centre Ireland, 2015). Migrant workers have reported experiencing less favourable terms and conditions than their work colleagues as well as discrimination (ibid, 2015). Poor care practices are intrinsically associated with poor working conditions and exploitation of the workforce (Trade Union Congress, 2014; Stone, 2016). Some managers have called for the commissioning agencies of the private home care industry to establish and enforce standards of best practice to ensure equal treatment for migrant home care workers:

I mean I think these are good people, they are coming to our country to work and as commissioners, we should be insistent on a level of a preparation for individuals in terms of their rights as individuals and their right to the basic level of working. (KSH10; L378-381)

In summary, research respondents have identified several concerns in respect of the increasing reliance on unregulated HCAs employed as lone workers by home care support agencies. These include restricted training opportunities, pay and conditions of

employment, risks associated with lone working for the HCA and patient, absence of supervision and the exploitation of migrant workers. As a consequence research respondents have noted the need for regulation of this industry and the imposition of standards of best practice.

5.4.1.2 Supervision in Practice

This sub-category presents the findings of HCAs' experiences and senior managers' observations of supervision in practice in the Irish health service. The HCA role is perceived to have a degree of autonomy for practice that is not always closely supervised or supported, such as when HCAs attend patients in their homes in the absence of direct supervision. This means that the reliance that would normally be placed on effective close relationships and supervision in hospitals may not be able to be provided in these settings, and the risks to patient safety from unregistered practitioners would still be present. However, most were aware that they should be supervised and many did express concern at the lack of guardianship provided. The following example reveals the frustrations of one HCA who works in the community with very little support or supervision from the registered nurse and ultimately is left with a sense of abandonment and isolation:

If you go into a house and you find a lady on the floor, obviously, you'll ring 999 and then you're told to refer back to her family, you'd hope you have a number for the next of kin, but you are supposed to report it back to the nurse and sometimes they are not always around, so you can be left very isolated when you are in the community. (HCA9FGE; L 693-699)

Also concerning are reports of questionable levels of supervision for HCAs in some healthcare residential settings. Current policy direction is leading to registered nurses being increasingly replaced by HCAs with the consequence that there are a diminishing number of registered nurses to provide the necessary supervision to an increasing number of HCAs (HSE, 2014a). The following extract would be typical of a care of the older person residential service whereby HCAs are now delivering the majority of bedside care with little or no supervision:

In care of the elderly there tends to be a lot more care assistants, so care assistants are doing the bulk of the patient care, and you don't have the assistance of a nurse all the time and most of the time you are getting on with it. (HCA4FGP; L 418-421)

Equally, in the acute hospital clinical setting, there is an increasing reliance on HCAs to provide the fundamentals of care unsupervised, while registered nurses are engaged in expanded roles, administrative functions and overseeing care for critically ill patients. One of the more potent examples was posited by the service user representative who described her mother's experience of neglect at the hands of an unsupervised HCA:

My sister walked in one day to find mum sitting on the bed and she wasn't so responsive and she was at risk the whole time of having a seizure, because she had suffered trauma to the brain. She (sister) walked in and there was a healthcare assistant with her who was just standing there watching the television and mum was just frothing at the mouth, she wasn't very responsive at all and my younger sister just panicked, absolutely panicked when she seen her in that state. Can you imagine what would have gone on if we weren't going in on a daily basis? (KSHSUR; L 119-128)

Clearly, the above example was extremely distressing for the patient and her family and only heightened a sense of suspicion and mistrust of the standard of care provided to the patient in the absence of family members and appropriate supervision.

Senior managers acknowledge the challenges associated with the supervision of HCAs with an ever increasing workload placed on registered nurses. In the absence of adequate supervision the registered professional cannot be assured that safe quality care will always be delivered by the delegated HCA. The registered professional is therefore placing trust in the HCA that care interventions will be competently provided and the HCA will communicate back to the professional the outcome of those interventions. However HCAs may not always fully declare the extent of their practice which impacts on the registered professionals' ability to supervise and monitor the care provided to patients by HCAs:

There has to be a lot of trust that the midwife knows that the person is capable. There isn't a whole lot of time to supervise anyway, so if the person is sending someone off to delegate a task and the midwife is highly reliant on the person being firstly able to do the task, which is a given but also coming back and communicating if there is a problem. That can be a challenge if communication doesn't happen. (KSH2; L 248-252)

The picture presented above points to an ongoing diminution of supervision time for HCAs primarily as a consequence of an increasing workload and a reduction in the availability of registered nurses.

5.4.1.3 Delegation

Closely associated with supervision are issues of delegation. Mueller and Vogelsmeier (2013:24) define delegation as the transfer of authority by a nurse or midwife (the delegator), who is responsible for health care delivery, to another person to perform a particular role or activity that is normally within the scope of practice of the delegator. According to professional nursing and midwifery policy, delegation should be accompanied with appropriate supervision (NMBI, 2014). However, in practice this does not always occur as outlined in the previous category. This section will now explore the underpinning discord emanating from the data associated with the delegation of traditional nursing tasks to unregulated staff to perform.

The findings suggest that there are inconsistencies and uncertainties attached to this practice both on the part of the HCAs and the registered nurses which may ultimately compromise patient safety. In this study, HCAs expressed a sense of frustration with conflicting instructions and subsequent criticisms directed at them by different registered nurses. The emerging data presents a picture of confusion relating to several nurse supervisors delegating tasks while at the same time questioning HCAs on existing tasks delegated by other registered nurses:

You do one thing for one nurse and the next nurse will give out to you. So you don't know who to please like, you're frustrated then trying to keep everyone happy.
(HCA6FGW; L 626-628)

Inherent in this confusion is a perceived lack of leadership and direction and the subsequent consequences for the delivery of compassionate safe care. Another HCA points to inconsistencies in delegation of tasks between experienced and less experienced registered nurses. In the following example the HCA suggests that younger inexperienced nurses are hesitant about delegating a nursing task, whereas the older nurse will draw on her experience to be more inclusive and delegate appropriately:

If it's a younger nurse they'd say 'you stand back, you're the HCA and I'm the nurse, I'll do this' whereas if it was an older nurse who knew that you had a wealth of experience they'd say "any ideas?" (HCA3FGP; L 271-276)

This perceived lack of trust is harmful for professional relationships between registered health professionals and HCAs. These sentiments generally found congruence with senior managers who suggest that there is still a 'fear of delegating from the nurses' perspective'. Managers also propose that the competency and confidence associated with the art of delegation is variable and dependant on the individual registered nurse as well as the specific nature of the intended delegated task:

I think it probably comes down to the individual Registered Nurse and how competent he or she is or how capable they are in relation to the delegation of tasks and skills and with specific elements of care. (KSH5; L 104-106)

These difficulties in delegating tasks arise from a lack of education and training for registered nurses and a subsequent lack of clarity in the roles of HCAs. An educational awareness programme for nursing staff to understand the principles of HCA training, appreciate the role of the health care assistant, and increase the registered nurses' knowledge and awareness of accountability in relation to delegation and supervision of healthcare assistants is available nationally through the health service education centres. One senior education manager amplified the importance of registered nurses attending this programme as many misunderstand the process of delegation with the consequence that HCAs have work 'dumped' on them inappropriately:

There is a huge need for Nurses and Midwives to undertake education and training on effective delegation and I know from the participants that come into the classroom delegation is misunderstood where healthcare assistants are concerned. There could be a lot of actually dumping stuff to them without realising what they're actually capable of doing. (KSH8; L 43-48)

A further factor identified by senior managers that contributes to the confusion in delegation is the absence of clear requirements and standards for the training and practice in respect of HCAs. Comparisons are made to student nurses and registered nurses who are guided by standards of practice established by the regulatory authority. No such standards

exist for HCAs which contributes to the uncertainty on the part of the registered nurse to delegate responsibilities to HCAs, which may compromise good quality care.

5.4.1.4 Accountability

Alongside supervision and delegation are issues of accountability. The Nursing and Midwifery Board of Ireland (NMBI) (2014:17) describe ‘accountability as being answerable for the decisions made in the course of one’s professional practice’. In its most recent edition of the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives, the NMBI (2014) is unambiguous in declaring that registered nurses are accountable if they make a decision to delegate a nursing task to someone who is not a registered nurse. The findings from this study point to uncertainty and concerns with accountability at the interface between HCAs and registered nurses for delegated tasks. It should be noted that the extracts outlined below are representations of the views of senior managers only (all nurses). HCAs did express views regarding accountability in the context of professional regulation for their group which will be addressed in theme five. A constant concern presented in the findings was the extent of professional accountability for tasks delegated to HCAs that remained with the registered nurse. This sentiment is captured in the following extract that suggests that registered nurses are fearful to pass on responsibilities to HCAs as they are concerned that the accountability rests with them if something were to go wrong:

I think it is that Nurses and Midwives have a fear in delegating a task because they ultimately carry accountability for having delegated the task. Whereas, whilst a healthcare assistant may be responsible for carrying it out ultimately accountability still rests with the Registered Nurse. (KSH5; L 410-415)

This view is shared by other senior managers who further point to the uniqueness of the registered nurses’ role regarding delegation. They propose that when doctors delegate responsibilities to registered nurses, there is no threat to the doctors’ professional registration as the delegated task and the associated risk for that task has transferred to another registered professional i.e. the nurse. However, when a registered nurse delegates a task to a healthcare assistant, the risk for the registration still sits with them. This view is exemplified by the following senior manager:

Like a doctor might tell me to go down and do a set of observations and give an IV medication and then the risk is mine. But if I ask a healthcare assistant to go down and give medication and to do a set of observations and something goes wrong in that intervention, it is my registration, and that probably can affect the relationship on a patient care team between registered professionals and non-registered.

(KSH1; L 260-265)

This is an important finding as it points to concerns over the legal responsibility that lies with registered nurses over delegated duties to HCAs who are not professionally regulated. Furthermore, there is a very real chance that registered staff will remain reluctant to delegate progressive work and tasks to non-registered staff impeding progression for this group and creating tensions at the interface between HCAs and registered nurses.

5.4.2 Summary

This theme has described how the functions of the HCA role and the various diverse influences that shape the role impact on quality and patient safety. The important influencing factors are homecare support services, lone working, supervision, delegation and accountability. Template analysis shows a convergence between senior managers, HCAs and service user representative regarding many of these influencing factors. There was strong agreement for the harmonisation of practices and standards to be applied to home care support services, lone working arrangements and employment of migrant workers. However, respondents point to the following as ongoing risks to the public; unregulated HCAs working alone, lack of supervision, inappropriate delegation and confused accountability.

5.5 Theme 4: Opinions on HCAs accessing patient information

Previous themes have pointed to the direct care nature of the HCA role and the subsequent opportunity for HCAs to cultivate closer relationships with patients than nurses and therefore gather useful information about patients. HCAs are often the predominant recipient of important information regarding change in patient health status as a consequence of the greater time spent with patients together with the direct personal and clinical care activities undertaken with the patient (Spilsbury and Meyer 2004, Kessler et al 2010).

Theme 4 will now explore the views of HCAs, senior managers and the service user representative in respect of HCAs access to patient information and subsequent implications for quality of care. The theme is composed of three categories called access to patient information, clinical handovers and information asymmetry. Within these three categories are four sub-categories (see Table 5-4 below).

Table 5-4 Opinions on HCAs accessing patient information

Themes (Level 1)	Categories (Level 2)	Sub-categories (Level 3)
Opinions on HCAs accessing patient information	Access to patient information	Access levels Consequences for quality of care
	Clinical handovers	HCA participation in clinical handovers
	Information asymmetry	Privacy and rural communities

5.5.1 Access to Patient Information

Public interest theorists such as Arrow (1963) refer to the unevenness of access to patient clinical records among healthcare occupational groups, a concept known as information asymmetry. Other commentators hold that information asymmetry is a real phenomenon and results in variations in the information possessed by different healthcare professionals (Ludwig et al., 2010). The emerging data has found that HCAs often experience restricted access to both patient records and clinical handovers in comparison to their professional colleagues. However, this experience is variable across the Irish health service. This category is made up of two related sub-categories; *‘access levels’* and *‘consequences for quality of care’*.

5.4.1.1 Access Levels

Some HCAs have reported that they have complete access to the clinical records of patients that they care for and suggest that completion of data protection training together with signed confidentiality contracts is adequate justification for this level of access. Moreover, it was viewed as a requirement in specialist areas such as mental health and formed part of the overall assessment and monitoring of patterns of behaviour to determine any sudden changes in the patient’s condition:

Yeah we would know because we have a lot of mental illness and, you know, we need to know what signs to watch for, to see if there was a change so we would read the files all the time. (HCA7FGS; L 1107-1110)

Other HCAs have revealed a more restricted form of access whereby patient information is limited to personal details and any known risks associated with the patient's condition such as the risk of falls. However, one HCA despite having unrestricted access to clinical files was refusing to read them claiming that it was more appropriate for registered nurses to view them and update them:

We try not to look at anything, I just don't want to know, I have my own problems never mind looking at someone else's. The less you know the less you have to give away. The files are there but I think they are for nurses. (HCA5FGS; L 1051-1053)

This sentiment found an echo with the service user representative who expressed a sense of unease and vulnerability that unregistered HCAs should have access to the level of details contained within the clinical notes:

I know it's only in the patient's best interest that they have access to those notes but I mean absolutely everything is detailed in them, everything and you are giving away that right. I mean I have read the files myself, we have a copy at home and everything is documented. (KSHSUR; L 244-248)

Senior managers, on the other hand, were forthright in their support for all HCAs to have complete access to patient clinical records as part of the multidisciplinary team. Curbing this access to practitioners who deliver direct patient care regardless of their professional regulation status was viewed as not being in the best interest of the patient:

If I am a healthcare assistant working in direct patient care, I should get for the patient's sake all the information that will support me to deliver good quality patient care. So I think that yes, they should have access to as much information as anyone else who is giving direct patient care. (KSH1; L309-312)

In a further affirmation for support of the HCA accessing clinical records this senior manager felt that HCAs were competent practitioners in their own right and are therefore trustworthy enough to treat confidential patient information with caution and respect:

If you're part of the team then you are competent enough and should be trusted enough to be part of communication, be part of anything to do with the particular patients being cared for in the department. (KSH11; L 256-260)

5.5.1.2 Consequences for quality of care

Some HCAs and senior managers identified potential negative consequences for quality of patient care arising from restrictions in access to clinical records. They point to certain patient groups as examples of those who are at risk if the HCA is restricted from accessing their clinical files and therefore would have little or no knowledge to changes in their health status. These groups include patients with; special dietary needs, mobility restrictions, behaviours that challenge and patients who are critically ill. Furthermore, forbidding HCAs access to records can have even more serious consequences for the HCA, the patient and the public at large through the risk of contracting and spreading infectious diseases as outlined by this senior manager:

There's also an issue concerning the health and safety of people who don't know the full information and, for example, I've had people working in wards where the nurses were aware that a patient was carrying tuberculosis but the healthcare assistant was treating that patient without that knowledge. (KSH11; L 261-266)

In this example the HCA was the subject of information asymmetry, whereby professional nursing staff and the patient were in possession of more information than the HCA, thereby putting the HCA and wider public at risk. This risk to the public is referred to by public interest theorists as a negative externality whereby health care can impact people negatively beyond the person receiving and the person providing the care. This example is equally applicable under the previous quality and patient safety theme.

Another HCA stated with a sense of exasperation the consequences of being forbidden to access patient records for the required information, instead having to interrupt the registered nurse during medicine rounds and thereby increasing the risk of medication errors:

You see the nurses getting frustrated because you are asking questions and they're trying to get on with their meds and oh, it does be a nightmare. (HCA1FGW; L 991-993)

This category examined the findings in respect of authority of HCAs to access patient clinical records. The data presented suggests that access to patient files is patchy and restricted. Nevertheless, senior managers support the notion of HCAs having full access consistent with their professional colleagues. HCAs and senior managers outlined negative consequences of continuing to forbid HCAs access to clinical records which includes the risk of negative externalities.

5.5.2 Clinical Handovers

Clinical handovers refers to the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis (Department of Health, 2015). Research has identified handovers as a risky time in the care process, when information may be lost, distorted or misinterpreted (Borowitz et al., 2008; Owen et al., 2009; Philibert 2009). The significance of handover cannot be overlooked and is considered a crucial part of how healthcare practitioners communicate. This sub-theme will present the findings in respect of HCAs' contribution to clinical handovers in the Irish health service. The category is composed of one related sub-category; '*HCA participation in handovers*'.

5.5.2.1 HCA participation in clinical handovers

There is a strong sense from the data that HCAs are not always included in the clinical handovers with widespread disparity in practice. A few HCAs have reported active participation in the handovers between working shifts and point to strong leadership in this valued development:

I feel really valued, we have a CNM (Clinical Nurse Manager) at the minute who is actually encouraging that we partake in all handovers and are now starting to get a bit more involved with the paper work. (HCA3FGP; L 486-488)

However, many HCAs point to a sense of nonchalance and ambivalence on the part of registered nurses towards HCA participation in the transfer of patient information between

teams. In one of the examples below, the closing of the office door is taken as an unambiguous message that the HCA is not welcomed at the handover:

Yeah, sometimes they just close the door and you go and make a cup of tea, they don't care whether you come in or you don't, I think. (HCA4FGS; L 389-390)

Yeah they are not bothered whether we come in or we don't. I can go in if I wanted to go in, they wouldn't stop me but they wouldn't invite me. (HCA7FGS; L 1177-1178)

One HCA however was more forthright in her comments stating that her colleagues are forbidden by nursing staff to participate in handovers implying a sense of power and control being exerted over the HCAs by registered nursing staff:

There are places over there where they (nurses) won't let the HCA do the report. There are some places they will not let you in to do reports in the morning. (HCA4FGP; L 439-441)

However, one senior nurse manager whilst acknowledging that HCAs do not always form part of the clinical handover team in her location, did not concur that this was a deliberate exclusionary tactic adopted by registered nursing staff. Instead, she pointed to a workforce design challenge whereby HCAs were required on the clinical floor to maintain a safe environment while the registered midwives received the formal handover. She did concede that this ongoing practice can undermine the role of the HCAs and leave them feeling less valued:

I went into one of the wards and I saw one of the care assistants on the ward. The handover meeting was happening and the care assistants were out on the floor and I keep saying that it does make them feel they are of a lesser value than the midwives, but, the other extreme is how do you manage to keep a ward safe if you don't have somebody on the floor and the midwives have to get the handover. (KSH2; L194-201).

This ongoing exclusion of HCAs from patient handovers was perceived to be “dangerous” and compromising care. In some clinical locations, HCAs were the recipients of a ‘second

hand' report from registered nurses following the formal clinical handover. HCAs revealed receiving only scant information from the registered nurse that was perceived to be inadequate to meet the holistic care requirements of patients:

In the mornings we wouldn't be allowed to sit in on the report, we would have to answer the bells ringing or people wanting the toilet, so at the end of the report we'd go up to the nurse in charge and she'd have all the patients names on a list. You don't know anything about the patients' condition, you don't know if that patient got bad news over night. (HCA2FGW; L 936-942)

One senior manager was of the opinion that this practice of HCAs receiving a second hand report from registered nurses created needless duplication and would inevitably result in disjointed care. Another senior nurse manager was questioning the motives of nurses using exclusionary tactics to prevent HCAs from participating in the handovers and making them feel like outsiders. She described this practice as a worrying development:

They are caring for the patients; they are part of a team. Why are they not part of that and what's at the bottom of that? It worries me greatly so it's like they're the outsider on the team. (KSH10; L 295-298)

These concerns have prompted all of the respondents in this study to call for the inclusion of HCAs in the clinical handovers as a further step towards their integration as part of the nursing team and thereby reducing the asymmetry of information between HCAs and registered nurses. There was a consensus among respondents that HCAs, because of their involvement in direct patient care, were often the predominant recipient of important information regarding change in patient health status. Therefore, HCAs were well placed to pass this information on to the broader nursing team during clinical handovers:

I think it's very, very important to have your full nursing team actually at the handover report because healthcare assistants provide a lot of the bedside care as well in relation to patients and they pick up information from patients that can be critical pieces of information for a Registered Nurse. (KSH5; L 52-59)

Moreover, the inclusion of HCAs in patient handovers is viewed as more efficient by minimising unnecessary repetition or duplication of information throughout the working shift:

Surely 20 minutes of handover in the morning would probably save you 2 hours during the day asking stupid questions. (HCA4FGW; L 988-989)

5.5.3 Information Asymmetry

The previous category touched on the concept of information asymmetry whereby registered nurses have access to more or superior patient information compared to HCAs. There was also reference by the service user representative to knowledge that the HCA possess that patients do not. This category will examine these phenomena further from the viewpoint of HCAs, senior managers and service user representative. The findings will be presented under the sub-category privacy and rural communities.

5.5.3.1 Privacy and Rural Communities

Arrow (1963) refers to problems caused due to differences in the information possessed by healthcare service users (patients) and healthcare practitioners. An inherent power imbalance develops within the relationship between the practitioner and the service user which can increase the sense of vulnerability on the part of the consumer. This power imbalance in favour of the practitioner is a consequence of their access to private information about the person in their care (Nursing and Midwifery Board of Australia, 2010). Public interest theorists point to the necessity for the professional regulation of healthcare practitioners to correct this power distortion thereby ensuring that healthcare professionals are of a sufficiently high standard to safeguard the public and reduce uncertainties in the mind of the patient (Arrow, 1963: 966).

In this study, the service user representative reported unease with the level of access HCAs possessed in respect of patient information. Surprisingly, some HCAs also expressed a sense of discomfort with the same access to confidential information as professionals. Both HCAs and the service user representative placed their concerns in the context of small Irish rural communities where it was difficult to maintain a sense of privacy, confidentiality and trust:

Just for me I suppose like we are a small community, you have a lot of people from (name of town), I just don't want to be looking back and seeing someone's history and them thinking God she knows. (HCAFGS; L 1076-1078)

It's just that privacy thing and I think being from (name of town) and (name of town) is so small, everyone knows everyone and that's hard too because people talk and it is that whole trust issue then again. (KSHSUR; L 261-264)

Whilst the service user representative could comprehend why HCAs would require access to clinical records, it nevertheless remained a major source of concern for her as she revealed a sense of disempowerment and vulnerability of entrusting assistant staff with such confidential information:

It's a major issue. I think when you're, especially when you are in the system that long, as long as we've been and it's hard you know because you are dealing with so many different individuals and you almost hand over that right or that privacy to them and that's hard. (KSHSUR; L 235-238)

In contrast, no such concerns were evident in the data emerging from the senior managers. In fact senior managers argued for HCAs to have equal symmetry of information with professional colleagues such as nurses and doctors in the interest of safe patient care. A line of argument was that no practitioner including HCAs should be expected to deliver care bereft of critical clinical information.

So there should be nothing in a patient's record that patients have not already told a healthcare professional and the chances are the patient will tell the healthcare assistant when they're attending to their physical needs anyway. But why should a member of the team work in the dark? (KSH10; L 321-324)

In a further show of support for HCAs to have equal access to patient information senior managers point to existing contractual obligations that compel all healthcare staff to comply with codes of confidentiality:

They've got a code of confidentiality no more than a radiographer, lab technicians looking at someone's white cell count.... or porters who work in a mortuary and the

people they bring down deceased and they are from the locality, there is a code of confidentiality that every employee is obliged to. (KSH1; L 304-309)

5.5.4 Summary of Theme Four

This theme explored the views of HCAs, senior managers and the service user representative in respect of HCAs' access to patient information and subsequent implications for quality of care. The findings revealed that participation in handovers was patchy and HCAs' requests to attend handovers were frequently greeted with a sense of ambivalence by registered nursing staff. Template analysis shows a convergence between senior managers, HCAs and service user representative that HCAs should unquestionably be included in handovers to minimise unnecessary repetition or duplication of information throughout the working shift. It was also revealed that not all HCAs have access to clinical records. In fact the service user representative and some HCAs expressed a sense of unease that HCAs could have the same access to confidential information as professionals. These concerns are placed in the context of small Irish rural communities where it is perceived to be difficult to maintain a sense of privacy, confidentiality and trust. The service user representative further articulated a sense of powerlessness and vulnerability of entrusting unregulated assistant staff with such confidential information. This sense of information asymmetry in favour of the HCAs was not regarded reason enough by senior managers to deny assistant staff who are part of the direct care team access to patient clinical records. In fact, in contrast to the service user representative, senior managers support the notion of HCAs having full access consistent with their professional colleagues and point to existing contractual obligations that compel all healthcare staff to comply with codes of confidentiality. HCAs and senior managers outlined negative consequences of continuing to deny HCAs access to clinical records which includes the risk of negative externalities such as the spread of infectious diseases.

5.6 Theme Five: Perceived value of professional regulation for HCAs and the public.

The previous themes presented findings which suggest that unregulated HCA staff providing care to vulnerable patients with complex healthcare needs were viewed as a risk to quality and patient safety. Furthermore, this risk is heightened with the increasing reliance on HCAs to provide care unsupervised to vulnerable adults and children in their own homes with complex healthcare needs. These findings are compounded further by the uncertainty that exists among professionals regarding the sharing of critical patient clinical

information with HCAs to facilitate the provision of safe, compassionate care. The picture is also one of confusion regarding the evolving role of the HCA with the consequence of uncertainty and concerns with accountability at the interface between HCAs and registered nurses for delegated tasks.

In view of the aforementioned findings, theme 5 will now explore the perceived value of a professional regulatory framework for HCAs and the public. The theme will draw on the perspectives of the research participants as well as the findings from document analysis. Theme 5 contains three categories called public interest, self interest and proposed regulatory governance. Within these three categories are seven sub-categories (see Table 5-5 below).

Table 5-5 Perceived value of professional regulation for HCAs and the public

Themes (Level 1)	Categories (Level 2)	Sub-categories (Level 3)
Perceived value of professional regulation for HCAs and the public.	Public Interest	Rogue practitioners Preparation for the Role Standards of Practice Accountability
	Self Interest	Career aspirations and rewards
	Proposed regulatory governance	Proposed organ of administration Costs of Regulation

A particular focus of this theme is the extent to which HCAs seek out professional regulation in the interest of protecting the public as espoused by the public interest theorists or alternatively motivated by self interest as posited by public choice scholars. Both will be explored in the findings below.

5.6.1 Public Interest

The public interest theory of regulation contends that regulation is introduced to benefit and protect the public by intervening to correct inefficient or inequitable practices (Pigou, 1932). In other words it presumes public servants are impartial and altruistic and will implement regulation for the wider public good and not solely for their own benefit. On examination of the data through the lens of public interest, HCAs were acutely aware of

their obligations to protect the public and how the influence of regulation on their practice could strengthen this protection. This category will present the findings under four related sub-categories; 'rogue practitioners', 'role clarity', 'preparation for the role', 'standards of practice' and 'accountability'.

5.6.1.1 Rogue Practitioners

Throughout the transcripts, HCA respondents regularly made reference to the low barrier to entry for this occupational group. In section 5.2.1.1, some HCAs were disparaging of the QQI(FET) Level 5 training programme claiming that it was 'too easy' to complete and employees from other industries undertake the training as a fallback position in the event that they become unemployed. Along similar lines HCA participants were emphatically in favour of some form of regulation that would filter those who were genuinely interested in caring from those who were primarily motivated by money:

They will train quickly and then they are in there. An awful lot of them aren't at all interested in what they do as in caring for people it's just to get money. (HCA1FGS; L 1499-1502)

In fact, one HCA acknowledged that it was not uncommon to work alongside other assistants that exhibited poor practices and viewed regulation as the instrument that would help to remove rogue practitioners from the service:

We've all worked with HCA colleagues that are 'bad care assistants' and you know like that can be vexing, they have no passion and I think that's where regulation would come in. (HCA3FGP; L 1049-1052)

In one of their stronger arguments for regulation, HCAs point to the current lack of traceability of unregulated healthcare employees whereby HCAs dismissed from their work can commence employment in another similar setting shortly afterwards. This view found an echo with the following senior manager who had personal experience of this loophole and relied on the goodwill that existed between employing organisations to share intelligence on exiting employees in the public interest:

If a healthcare assistant is abusive towards a resident in a nursing home they can leave there and walk down the road and I've seen that, now you would obviously let

the other nursing home know but there is no regulation around that really.

(KSH12; L62-65)

However, an important functionality of a regulatory framework identified by HCA respondents that would help combat this risk is a central repository or register that would record details of HCAs including qualifications and any sanctions applied to their practice. This would facilitate transparency and traceability of employees as they move between employers thereby reducing the risk to patient safety and the public at large:

If I had a nursing home and a carer is coming in to me and I'd say "why have you been in seven different care homes in the last 5 months?" and that traceability is there on a computer. (HCA7FGW; L 1020-1022)

Senior managers generally concurred with the views posited by HCAs that regulation of assistant staff would enhance public protection. They also pointed to an argument held by public interest theorists that occasionally patients or the general public experience difficulties in evaluating the quality of healthcare services available and hence minimum standards are therefore a requirement if members of the public fail to recognise the risks associated with receiving low quality healthcare services:

I think the lack of standardisation and the lack of a minimum basic education level is still likely to be there if people can be employed coming in off the street and going in to somebody's home as a vulnerable person, whether it's a handicapped child, disabled child and a parent who doesn't necessarily have the wherewithall to advocate for those standards. (KSH2; L 402-406)

In a further argument in support of regulation of HCAs, senior managers questioned how some occupations that appear to present less risk to the public are subject to a form of registration and yet the HCA role is allowed to function unregulated. In the extract below, the senior manager respondent gives the example of a security person working in a pub who is mandated to have relevant training and a personal identification number for transparency and traceability:

Well if you think about it, right, if I wanted to be a security man in a pub tonight, I have to get regulated, I have to do the course, I have to get my pin up. I don't need

to do that to be a healthcare assistant, I can go in and administer care in a nursing home and I may have abused somebody somewhere else in a different country or in a different county and here I am. (KSH12; L421-426)

5.6.1.2 Preparation for the Role

It was already identified in theme two that whilst a nationally agreed programme exists for training of HCAs, there is no mandatory requirement for HCAs to attain any such qualifications. As a consequence, there is reported variability in the education and training received in preparation for the HCA role. Thus, the fact that their practice and education are not regulated means that consistency of standards cannot always be guaranteed. Furthermore, both HCAs and senior managers point to a restrictive learning environment where there is little evidence of CPD opportunities. Given that the role is evolving as evidenced in Theme 1, it is worrying that this evolution is not consistently underpinned with relevant CPD opportunities.

Moreover, there is an overwhelming sense from the data that the public and, specifically, patients are entitled to know that the person who is caring for them, the HCA, has received relevant training and education that allows them to provide front line care competently:

The patient or the member of the public who is receiving care is entitled to know that the person treating them or involved in their care is appropriately qualified to the standard expected by the State and expected by other medical professionals. (KSH11; L341-344)

A common concern raised by all participants in an earlier theme was the notion of the unregulated HCA with questionable qualifications and skills sets working with vulnerable adults and children in their own homes unsupervised. The argument therefore appears to be strengthened that the baseline educational standards for HCAs should be protected through regulation to safeguard consistency in practice. Moreover, risks associated with care interventions in less controlled environments such as patients' own homes are magnified (Health and Safety Authority, 2011; Health Service Executive, 2012; O'Shea, 2013) prompting this senior manager to call for regulation, licensing and credentialing of HCAs who provide personal and clinical care in people's homes:

One of the reasons that we've been pushing for the regulation of health care assistants is that only qualified health care assistants should be licensed to go into people's homes and care for them. (KSH11; L290-292)

Finally, completing the case for professional regulation of HCAs to establish minimum standards of education and training is the suggestion that patients would be more comfortable and more confident in the ability of a registered HCA. The rationale for this argument as outlined by the HCA below is that the qualifications of the regulated HCA could be certain, thereby giving the public the confidence that HCAs have been educated to the requisite level and are licensed to practise:

For the patient, I think they would feel probably more at ease because they would see you in more of a professional role. They would see you as more of a confident and competent person. That is why I think regulation would be good. (HCA3FGP; L 655-658)

5.6.1.3 Standards of Practice

Concern was expressed in section 5.4.1.1 that an increasing reliance on unregulated HCAs to provide direct patient care compromises quality and standards. Currently, the fact that their practice is not regulated means that consistency of standards cannot always be guaranteed and consequently patients would be exposed to unnecessary and unjustifiable risk. Therefore, HCA respondents view professional regulation as an opportunity to standardise and assure the quality of their practice as well as being held accountable for their actions:

I do feel that there is a need for some form of regulation to be applied to us so that we can safely practice within our own area, within our own scope of practice and also that we are going to be held responsible for our acts and omissions. (HCA1FGW; 13-19)

Central to the argument for regulating the practice of HCAs are repeated references to recent scandals in the Irish health service involving HCAs. One such scandal was revealed by the RTE Prime Time Investigations Unit in Aras Attracta, a residential respite and day service facility. Many HCA and senior manager participants contend that this scandal among others is sufficient justification for seeking regulation for HCAs in Ireland:

I certainly think with given the Aras Attracta scandal that has arisen, the whole thrust of again the litigious environment we are in etc, I think there is a lot to be said for regulating healthcare assistants too. I think it certainly would protect the public. (KSH2; L 355-359)

Research participants acknowledge that there is an expectation from all health service staff to challenge poor practices and escalate concerns relating to evidence of shortcomings in care and abuse of patients. The findings suggest that professional regulation of HCAs would heighten the additional expectations from them as a group and enhance their confidence and sense of responsibility to escalate concerns regarding any issues they encounter in relation to quality and patient safety:

It may improve the confidence of the people that are in the role to actually put their hand up and say, I now know where I fit into a structure, and I can escalate a situation if I'm uncomfortable with it. (KSH7; L510-513)

Furthermore, senior manager participants concede that registered nurses cannot provide supervision to every single HCA undertaking every single task. This is particularly relevant for HCAs who provide care interventions for vulnerable adults and children in their own homes. It is therefore difficult to determine or measure the quality of care patients receive from unregulated HCAs in the absence of direct supervision. The following extract therefore implies that regulatory processes will help to assure the quality of HCA practice as well as the standard of their care:

You don't know what kind of quality of care a patient or a client is getting unless the nurse supervises every delegated task they do. So as a professional nurse if there isn't some kind of regulation, when you delegate a task to a non-registered professional to go and care for a patient in your remit, you have no true assurance that there is safe quality care being delivered unless you actually go down and supervise it. I do think that regulation will enhance that. (KSH1; L 386-391)

5.6.1.4 Accountability

The findings from theme 5.4.1.3 of this study point to uncertainty and concerns with accountability at the interface between HCAs and registered nurses for delegated tasks. Of particular concern were fears on the part of registered nurses to pass on roles to HCAs in

the absence of regulation as they are unsure of where the accountability lies if something were to go wrong. This lack of “trust” is harmful for professional relationships between registered health professionals and HCAs. There is a strong sense from the data in this category that research participants felt that HCAs should be accountable for their own practice and professional regulation would provide this assurance:

We would be more answerable for the things that we do and don't do in our job if we are regulated. (HCA5FGS; L 1216-1217)

Therefore, rather than seeking to abdicate responsibility when faced with the consequences of their actions, HCAs have clearly indicated readiness to accept responsibility and accountability for their practice. Senior managers in the main agree that the current situation is unsatisfactory and accountability of HCAs should be monitored through a regulatory body. However, for one manager, the concern appears to be less about public protection and more about safeguarding the interest and registration status of the registered nurse:

The nurse is rightly concerned about her pin, but why shouldn't the other people that report into her also have the same responsibility? (KSH12; L409-410)

The findings presented in this category suggest that HCAs' desire for professional regulation is strongly motivated by a sense of responsibility to protect the public. They pointed to public interest benefits such as traceability of rogue practitioners, consistency in standards of preparation and practice for HCAs, more accountability for actions and ultimately greater confidence on the part of the public in HCAs as competent practitioners.

5.6.2 Self Interest

A particular focus of the previous category was the extent to which HCAs seek out professional regulation in the interest of protecting the public as espoused by the public interest theorists. An opposing view to the public interest theory of regulation posited by the proponents of public choice is that “*regulation is supplied in response to the demands of interest groups struggling among themselves to maximise the incomes of their members*” (Posner, 1974: 335-336). An important feature of the public choice theory is that it abandons the notion that regulation is an instrument to pursue public interest. The data for

this category were examined through the lens of the public choice theory and are presented under the following sub-category; ‘*career aspirations*’ and ‘*rewards*’.

5.6.2.1 Career Aspirations and Rewards

It is evident from the accounts given by HCAs that they do not strive to be just another pair of labouring hands but desire to develop careers, professional identities and work with a meaningful role. A substantial proportion of the HCAs interviewed expressed a sense of frustration and disheartenment that there were very few opportunities for career advancement within their structure to progress them further in seniority or salary. The primary professional direction is into nursing but this is limited. However, for some, entering nursing is neither an option nor a desire and therefore regulation is viewed as an opportunity for HCAs to pursue viable career options within their own structure:

And I would hope as well within regulation there would be potential for advancement of career, within the structure of the healthcare assistant.... It is very disheartening to be within any role where there is no potential for advancement and the only option to advance is to get out of it. That's a loss to the role. (HCA4FGP; L698-703)

HCA respondents agreed that if there was a recognised career pathway and more opportunity then more people would be attracted to the role and remain in the role. One HCA expressed a desire for a discreet management pathway for assistants that would enhance career progression and reward for working as a HCA in Ireland. Furthermore, this respondent implies that a HCA who becomes a manager will have greater empathy for the HCA role than other professionals and thus will advocate for their members within a governance structure:

Every grade in the hospital has their own management structure, we don't, and I think we badly need it and we want somebody who understands us as healthcare assistants. So we need a healthcare assistant to be made a manager of healthcare assistants because they will know exactly what it's like to be a care assistant. (HCA4FGP; L 699-703)

The opinions and desires expressed by HCAs for a structured career pathway largely found congruence with senior managers and there was even the sense that HCAs were being

marginalised. One manager noted that as a consequence of this lowly recognised status and lack of a career pathway, HCAs would continue to employ self destructive dialogue such as *'I'm just a healthcare assistant'*. This manager's comment was fully compatible with the sentiments expressed earlier by HCAs in supporting their aspirations for a unique career pathway for this occupational group:

There's no reason in the future why I wouldn't see a care assistant become a care assistant manager, and that they would manage and do the supervision etc., in the future. (KSH9; L352-355)

This sub-category has highlighted the impact of the absence of a career pathway on the value placed on the HCA role in Ireland. The only viable option for the advancement of HCAs is to enter nurse training. Professional regulation has prompted both HCAs and senior managers to suggest that a distinctive and recognised career pathway would significantly enhance the attractiveness of this role as realistic career choice.

5.6.3 Proposed Regulatory Governance

There is a consensus that HCA staff should be regulated as a single group within a single framework and most believed that proportionate and responsive regulation was a way to protect the public. However, regulating a new group of health workers is not a simple task. A number of factors need to be considered including the model of regulation to employ, the proposed organ of administration most suitable to govern this group and the cost to HCAs who may earn significantly less money than other healthcare professionals. This final category will present the findings under the following two related sub-categories; *'proposed organ of administration'* and *'costs of regulation'*.

5.6.3.1 Proposed Organ of Administration

Research participants in this study have contested who would regulate HCAs. The Nursing and Midwifery Board of Ireland (NMBI), which currently regulate nurses and midwives and set standards for nursing and midwifery practice, presents the most obvious regulatory solution for HCA practice. This is based on the fact that these roles exist to assist registered nurses and the practices associated with HCAs have their origins in nursing. Indeed, some of the senior manager respondents (all nurses) were of the opinion that if

there is a decision to regulate the HCA, and the role is conceived as part of the nursing family, they believe the NMBI is the appropriate body to regulate the role:

It should be in nursing because it is predominantly nurses that are delegating the tasks. (KSH1; L 402-403)

However, others believe that the NMBI is not the correct body to take on the regulation of HCAs. They point to the fact that the subservient role of HCAs would become more pronounced and they would constantly feel beholden to nursing. Furthermore, as pointed out by this trade union leader, the NMBI framework is designed to regulate practitioners educated to more advanced levels than HCAs:

The system being operated by the NMBI, for the people that we represent in the health care assistant profession, we believe that's not a suitable model...our members are not doing Degrees or Masters in medical care or emergency care or care of the elderly or maternity care. (KSH11; L 390 – 394)

Nevertheless, the NMBI is only one part of the regulatory jigsaw. Another option for regulation of HCAs posited by some participants was the Health and Social Care Professional Council (CORU), a multi-profession health regulator that was established in 2005 to provide statutory regulation for thirteen different professional groups. It is envisaged that CORU could provide the requisite governance for HCAs and is favoured by a national HCA representative group:

So probably CORU because CORU I think is in that space and I know that the Health Care Association Ireland is pushing for CORU to become the regulatory body. (KSH4; L 434-437)

However, deeper analysis of documentation shows that CORU may not provide the appropriate and timely solution for HCA regulation. This is based on the fact that CORU to date has regulation in place for nine of the fifteen professions under their umbrella. Therefore, there remains, as a priority, a significant body of work to complete and to open the remaining registers associated with the outstanding professions. An alternative organ of administration posited by a trade union leader was the Pre-Hospital Emergency Care Council (PHECC), established in 2000 to regulate emergency medical services

practitioners. This independent statutory agency currently regulates emergency medical technicians (EMTs) many of whom transitioned from lower status roles in patient transport services. This trade union leader clearly sees parallels with the HCA journey and therefore views this model as an appropriate fit for HCA regulation:

We think that maybe something like the model that the Ambulance Service use which is the Pre-Hospital Emergency Care Council, and... we think that that's the kind of model our members will fit into. (KSH11; L396-403)

However, on deeper analysis HCAs would not meet the criteria to have their names entered on the PHECC register of practitioners as none of them are employed as pre-hospital emergency care practitioners and do not hold a National Qualification in Emergency Medical Technology (NQEMT).

This then leaves the question of which of the other regulatory bodies could provide a solution. One HCA respondent suggested the establishment of a new independent regulatory board that would provide the regulatory oversight for HCAs in Ireland. Overall, however, there appears to be little consensus within the data on the most appropriate regulatory authority, should a decision be made to regulate HCAs. This decision will ultimately be a matter for the Minister and the Government of the day to consider. This discussion will be developed further in the next chapter.

5.6.3.2 Costs of Regulation

As can be imagined the issue of the cost of regulation is a thorny one with HCAs themselves. The administrative cost is traditionally borne by the members of the profession through initial registration and thereafter subsequent annual retention fees. There was a general acceptance among research participants that HCAs should meet the costs of their registration. Some HCAs, though, were of the opinion that the annual retention registration fees to remain on the professional register should be absorbed by the employer:

Should the employer pay for it? I am thinking, you employ me, I do a good job, I'm fully trained, so you should be glad to have me and pay for my fee. (HCA5FGE; L 1186-1188)

However, this was not a widespread perspective and generally HCAs could appreciate the added value that regulation would bring in terms of training, standards of practice and assurance of competence and therefore have stated their readiness in principle to pay to be regulated:

But when you think about it, your FETAC level 5 is a lifetime award. FETAC, level 6, that's a lifetime award. That cannot be taken from you, so why should you not pay for it, you know, you're going to be registered, you're going to be regulated. (HCA1FGW; L 1088-1091)

Notwithstanding this stated position, HCA respondents warned that any costs attributed to them for regulation needs to be fair and in accordance with their income and qualifications. Several HCAs made reference to the registration fees for nurses and indicated that it would be unfair to be expected to pay the mandated €100 annual retention registration fee. This is based on the fact that HCAs earn significantly less than registered nurses. Likewise, the fee of €100 per annum charged by CORU was also viewed as excessive. This has prompted some HCAs to suggest that the registration fees charged by PHECC at €10 per annum is more fitting for their group and justified this claim on the basis that unlike registered nurses, HCAs are not required to be trained to degree level or expected to pursue specialist clinical career pathways:

I know for PHECC, it's a very low fee and nothing like the nurses with four year degrees and I think we should be more on that level. (HCA7FGE; L 1174-1176)

5.6.4: Summary

This theme explored in depth the perceived value of a professional regulatory framework for HCAs and the public. The findings revealed that HCAs' desire for professional regulation is strongly motivated by a sense of responsibility to protect the public. They point to public interest benefits such as traceability of rogue practitioners, consistency in standards of preparation and practice for HCAs, more accountability for their actions and ultimately greater confidence on the part of the public in HCAs as competent practitioners. From a self interest perspective HCAs view professional regulation as a vehicle to pursue viable career options within their own structure and significantly enhance the attractiveness of this role as realistic career choice. There appears to be little consensus within the data on the most appropriate regulatory authority, should a decision be reached on the regulation of

HCAAs. Overall, however, both HCAs and senior managers acknowledge the added value that regulation would bring in terms of public protection with the consequence, therefore, that HCAs have stated their readiness in principle to pay to be regulated.

5.7 Conclusion

This chapter presented the study's findings under five main themes (*Perceptions on the Evolving Role of the HCA in Ireland, Preparation for the HCA role; The impact of the role on quality and patient safety; Opinions on HCAs accessing patient information; and Perceived value of professional regulation for HCAs and the public*), which illustrated participants' perspectives of professional regulation for HCAs.

In this study, HCA participants have revealed an overwhelming sense of non-recognition and a lack of value placed on their role, a perception that finds congruence with senior managers. The reported variability in training for HCAs contributes to this sentiment. Such is the disparity in priorities for HCA training that the findings point to a three-tiered workforce reflecting qualified, partially qualified and non-qualified HCAs. Consequently, senior manager participants have reported confusion and tensions at the interface between HCAs and registered nurses for delegated tasks as nurses are uncertain of the competencies of the HCA receiving the task. Furthermore, the findings report criticism of the HCA training suggesting a disconnect between theory and clinical practice. The findings also point to the following as ongoing risks to the public: unregulated HCAs working alone, lack of supervision, inappropriate delegation and confused accountability. One senior manager confirmed a concern raised by McKenna et al (2004) that an HCA dismissed by one employer can gain employment with another employer unchecked as there is no national register. Also crucially significant was the variation in practices and perspectives associated with handovers and access to patient files in respect of HCAs. The findings overall suggest that professional regulation would assist in addressing the aforementioned concerns and anomalies, but there is little consensus within the findings on the most appropriate regulator to provide the necessary governance. The next chapter considers these findings in the context of contemporary literature.

Chapter 6 Discussion

6.1 Introduction

This thesis is concerned with the evolving role of the healthcare assistant in the Republic of Ireland and its implication for professional regulation with a focus on public protection. This chapter draws together the study findings underpinning the thesis and examines these in the broader context of the extant literature reviewed in Chapter two and Chapter three with a view to formulating recommendations for practice. This chapter demonstrates where the research findings contradict, extend, or coincide with the literature review. Moreover, in exploring the changing HCA role, the thesis demonstrates how the data collected and presented in Chapter four justifies the arguments put forward in this chapter. This chapter also makes use of the contrasting theories of public interest and public choice to enable further understanding of real-world phenomena associated with the unregulated HCA, the implications for public safety and the key drivers for professional regulation. Finally, the main themes arising from my research will also be discussed with regard to their relevance to Irish government and EU policy. This chapter will therefore provide the textual bridge between the findings in my fieldwork presented in Chapter 5 and the conclusions that I will draw from that evidence in the next Chapter.

As an aide memoire, I wish to restate the research objectives of this thesis.

6.2 Aim and Objectives

The aim of the thesis was:

To explore the changing role of healthcare assistants in Ireland and consider the need for professional regulation in the public interest

The objectives of the research were to:

1. Undertake an in-depth critical review of the extant published literature regarding unregistered HCA staff and the relevant discourse regarding professional regulation

2. Seek to understand the views of the healthcare assistants in respect of their changing role and subsequent future regulation for their profession
3. Assess the views of other key stakeholders in Ireland in respect of proposed introduction of healthcare assistant regulation
4. Determine the levels of risk if any associated with this workforce continuing to provide front line clinical care while unregulated

The discussion of the research findings in this chapter is grouped under the five themes introduced in the previous chapter. The competing theories of public interest and public choice introduced in chapter 3 are used to frame the discussion.

6.3 Perceptions on the Evolving Role of the HCA in Ireland

In this study, findings suggest that the experiences encountered by HCAs in respect of evolving role responsibilities and working practices are variable and context specific. Whilst there is evidence to suggest that HCAs are experiencing increasing levels of responsibility with some claiming that they are currently working beyond their parameters of practice, others express frustration at the perceived stagnation of the role and under-utilisation of their skills. For example, some HCAs reported expanded administrative and financial management responsibilities analogous with the role of a middle manager and therefore beyond the scope of practice of the qualified HCA, others revealed a culture that prevents HCAs from using their full range of clinical competencies in practice. The data suggest that the inconsistency in the evolution of the responsibilities and working practices of the HCA creates confusion within teams and the pattern is perceived by senior managers and HCAs as having implications for quality and patient safety. Such findings support previous national and international research on HCA roles (Thornley 2000; McKenna, Hasson and Keeney, 2004; Spilsbury and Meyer 2004; Hasson, McKenna and Keeney, 2013 and Cavendish, 2013). All these studies reported variability in the application of the HCA role which raises serious quality and patient safety questions.

The research participants in this study point to a number of factors that contribute to the uneven utilisation of the HCA role to include poorly defined occupational boundaries between HCAs and registered nurses, perceived similarities between HCAs and other related grades such as multi-task attendants (MTAs) and the range and complexity of tasks

delegated to HCAs by registered nurses on an ad hoc basis. However, a repeated theme emerging from the findings is the absence of an unambiguous job description or job profile detailing the tasks, responsibilities and scope of the HCA role. This anomaly was described as a source of concern for HCAs and perceived to be a significant contributor to the inconsistent deployment of HCA skills. Such reports are not new and echo Cavendish's (2013) findings in her review of the health care support workforce in the UK.

A generic national job description for HCAs had been developed in the HSE in 2006 for adaptation by local services to reflect local service needs (HSE, 2006). On examination of this job description (Appendix 16) the outline of the role is both vague and nonspecific and does little to negate the variability in the application of the role as reported earlier. Furthermore, the job description acknowledges the existence of qualified and non-qualified HCAs as reported in the findings and only exacerbates uncertainty, among registered nurses, about what tasks they can safely delegate. Cavendish (2013) raised similar concerns.

The scope and parameters of the HCA role are also absent from this job description which only heightens the sense of confusion and ambiguity surrounding their practice. It is not surprising therefore that this study has found evidence of both misuse and under use of HCAs with the consequence that site specific variations in the deployment and development of assistant staff is likely to continue. Similar research findings were reported by Spilsbury and Meyers (2004), Kessler et al (2010) and McMullen et al (2015). This adds weight to the argument that the HCA role should be clearly delineated through a revised national standardised job description and a legally defined scope of practice (see Storey, 2007; Cavendish 2013). These instruments will illuminate the safe boundaries of practice for HCAs and when considering opportunities for expanding the scope of HCAs in the future.

Both senior manager and HCA participants in this study have indicated that the HCA has evolved sufficiently to become the predominant front line carer, a status that was once the preserve of the registered nurse. The data suggest that this change has occurred as a consequence of other competing demands on the time of the registered nurse such as additional bureaucratic and administrative responsibilities and expanding clinical roles, thereby creating the space for the HCA to become the primary point of accessibility to the patient and public. Such findings are not new and reflect recent UK studies (see The

British Association of Critical Care Nurses, 2003; Bach, Kessler and Heron, 2008; Spilsbury et al, 2013). However the findings also point to a sense of resentment and frustration on the part of some HCAs towards registered nurses and their increasing administrative responsibilities interpreting it as a means of avoiding the genuine nursing work. Others articulated a sense of mystery and obscurity in relation to the changing focus of the nurse's work and the requirement to be increasingly office bound. Although, not widely reported in the literature, Daykin and Clarke (2000) and Kessler et al (2010) do confirm these findings.

Whilst there is justification for the time spent by nurses meeting their administrative and regulatory obligations, the data also suggest that an unnecessary boundary has been created between the nurse and the patient and also between the nurse and the HCA. It also raises issues about the registered nurses' ability to supervise and monitor care provided to patients by HCAs whilst the nurse is distant from the front line. This theme will be revisited later in the discussion chapter.

In reviewing the literature, several studies have reported increasing ambiguity and blurring of the role boundaries between the registered nurse and the HCA, resulting in confusion for staff, patients and the general public (Spilsbury and Meyers, 2004; Stokes and Warden, 2004; Bosley and Dale, 2007). The findings from this study were inconclusive. HCA participants reported little variation between their roles and registered nurses and therefore corroborate the findings of previous studies. However, in contrast, senior managers revealed that the less visible features of the registered nurses' role, such as higher levels of responsibility, accountability and clinical decision-making clearly distinguished them from HCAs.

6.4 Preparation for the Role

An important perspective in the whole question of regulation and the changing role of the HCA is how the research participants view existing training opportunities and the desirability or otherwise of regulation.

Findings from this study reflect a failure to mandate the QQI (FET) level 5 training for all HCAs when introduced to the Irish health service in 2001. This failure means that HCAs in Ireland are delivering direct patient care with no statutory duty or policy for them to have any type of qualification or agreed training. As a consequence, an uneven approach by

employers to standardise the requirement for HCA training at entry level has ensued as described in section 5.3.1.1. Consistent with the findings of this study, national and international evidence indicates that the lack of regulation has given rise to training that is variable and non statutory for HCAs (Bosley and Dale, 2007; Sprinks, 2009 and Cavendish, 2013). As a consequence, a three tiered assistant workforce has emerged with a mixture of qualified, partially qualified and unqualified HCAs working together with vulnerable patients. Senior manager respondents in this study reported that the educational disparity between HCAs was a source of confusion for registered nurses who were unclear about the distinction in knowledge and competencies between the qualified and non qualified HCA. Furthermore, some unqualified HCAs had significant pre-existing clinical experience which concealed their lack of underpinning knowledge. These hidden disparities in knowledge and skills between qualified and non qualified HCAs were perceived to pose a risk for the registered nurse regarding the safe and appropriate delegation of tasks and by extension a risk to patient safety. Spilsbury and Meyers (2004) warned that registered nurses regularly made assumptions about the knowledge and ability of HCAs to perform specific tasks, whereas the findings in this study would suggest that this is a high risk strategy given the inconsistency in training and qualifications of HCAs. Delegation will be re-visited in the next section. Nevertheless, there is a general undercurrent of good will and positivity directed towards the nationally agreed programme, but the findings would suggest a requirement for a policy change to mandate and standardise HCA training going forward.

As well as the variability in the application of the HCA training programme nationally, the findings from this study also reported examples of classroom theory from the programme not reflecting the realities that HCAs face in the dynamic clinical workplace. This experience of disconnect between learning and clinical practice is more pronounced for those HCAs with no pre-existing clinical experience. This finding is inconsistent with a previous Irish study that sought the views of healthcare managers in respect of HCA training and reported high levels of satisfaction (Keeney et al, 2005). However, a recent report into widespread abuse of vulnerable residents by regulated and unregulated healthcare staff in Ireland revealed that staff were not sufficiently trained to appropriately care for residents with behaviours that challenge (HSE, 2016). Moreover, congruent with the findings of this study, the report described a *'lack of opportunity and support for the positive transfer of training skills into the workplace'* (ibid, 2016: 71) confirming the ongoing existence of a disconnect between classroom learning and clinical practice.

On a related matter, the findings from the current study also suggest that HCAs can attain their qualification without sufficient clinical placement experience to complement the theoretical content of the overall programme. As a consequence some HCAs feel totally unprepared for the realities of their new role. Diluting the significance of clinical placement experience in the overall composition of the course is not consistent with best practice for preparing practitioners for front line care (Centre for Allied Health Evidence, 2006; Kessler et al, 2010; Brown and McMurray, 2014). In fact an EU commissioned study recommended that *'the training should include a minimum of 50% of on-the-job supported learning in practice'* (Braeseke, 2013: 51). Therefore, alterations to educational preparation with a more balanced mix of theoretical input and practical clinical exposure would enhance opportunities for HCAs to apply their knowledge to practice. Prior studies have noted the importance of national guidance and standards for HCA education that would promote greater consistency in the provision of entry training (Saks and Allsop, 2007; Cavendish, 2013; Royal College of Nursing, 2015). Some believe that standardised frameworks for HCA training should be underpinned by appropriate regulation (Saks and Allsop, 2007; Griffiths and Robinson, 2010; Royal College of Nursing, 2015). HCA training will be re-visited in the next part of the discussion below.

Training requirements and standards frameworks are a regular feature of professional regulatory authorities and provide consistent guidance for the development of practice-oriented education programmes for the relevant training providers involved in the education and training of the members of the regulatory body.

6.5 The impact of the role on quality and patient safety

The results of this study indicate that there are ongoing risks to the public associated with the employment of unregulated HCAs. This finding confirms the results of previous research that examined the association of unregulated HCA staffing levels with hospital mortality rates and episodes of missed care (Needleman et al, 2006; Aiken et al, 2014; Griffiths et al, 2016). These studies all point to higher numbers of less trained assistant staff or a diluted nursing skill mix to be associated with higher mortality or other associated risks. This has led Griffiths et al, (2016: 6) to conclude *'current policies geared toward substituting HCAs for registered nurses should be reviewed in the light of this evidence'*.

Significantly, the practice of HCAs working alone, unsupervised with vulnerable patients in their own homes, was the source of greatest concern amongst research participants. Interestingly, the demographics in Ireland point to a growing reliance on HCAs delivering home care support with the population of people over 65 growing by approximately 20,000 each year while the over 85 population is growing by 4% annually (HSE, 2015b).

The subject of the home care industry drew widespread criticism from respondents in this study for many reasons. Senior managers viewed the lone working model as having its own unique set of risks both for the employee and the patient. Risks are known to be magnified when procedures are carried out in less controlled settings, such as in patients' homes (O'Shea, 2013). Furthermore, HCA participants were critical of the employment conditions of colleagues, reporting that they carry an enormous workload, but are paid poorly, suggesting they were the subject of exploitation. This view is supported by the Migrant Rights Centre Ireland, (2015) who have heavily criticised the home care support industry for the conditions under which migrant workers are employed including reports of poor conditions of employment and discrimination. Poor care practices are intrinsically associated with poor working conditions and exploitation of the workforce (Trades Union Congress, 2014; Stone, 2016). In the absence of regulation, respondents point to an urgent requirement for the commissioning agencies of the private home care industry to establish and enforce standards of best practice to ensure equal treatment, in particular for migrant home care workers.

Moreover it would seem to be in the public interest that a two-tier level of care does not develop. Thus those receiving care at home should not be subjected to lesser standards than regulated patient care in hospitals or other healthcare residential environments. In fact the Law Reform Commission, recommended in 2011 that HIQA should be given additional regulatory and inspection powers to regulate and monitor the undertakings of domiciliary care providers (whether public or private sector, and whether for-profit or not-for-profit). Worryingly, to date this industry remains unregulated in Ireland.

Further findings from this study indicate a worrying disparity in standards applied to the training of HCAs for the delivery of home care services as lone workers compared to the standards in place for assistant staff who work in hospitals and healthcare residential services. Currently, these HCA staff complete the full QQI (FET) level 5 training, which is composed of eight modules. This is in contrast to the HCAs employed in the domiciliary

care industry who are only expected to complete two of the eight modules (HSE, 2016). This was an unexpected finding, as the study did not have a research objective related to this area.

In concurrence with the literature, the findings from this study point to the lone working model as having its own unique set of risks both for the employee and the patient. Both parties are being left exposed and vulnerable to varying accusations such as abuse, violence or other forms of criminality (HSE, 2012). Furthermore, in accordance with their changing role, home care HCAs are providing increasingly complex personal care to very vulnerable clients, in their own homes and with increasingly sophisticated ‘hospital-at-home’ tasks to perform (Taylor and Donnelly, 2006). Whilst the majority of these workers will carry out their care-working role without incident, for some staff there may be times when they may be exposed to hazards such as violence and aggression (including physical and verbal abuse) and difficult work environments and may be at greater risk in the event of an emergency or if involved in a work related accident (Health and Safety Authority, 2011). Thus, it is not surprising that lone workers are classified as a vulnerable group (HSE, 2012). Some respondents expressed a sense of bewilderment and worry that, given the risks and hazards attached to such a role for both the patient and the employee, entry training requirements for the homecare support HCAs should be significantly less than what is demanded for assistant staff in hospitals where enhanced supports and supervision already exist. In fact, Cavendish (2013) recommended that that no HCA should administer care unsupervised until they had successfully completed their entry training.

Another important finding from this study was reports of ongoing diminution of supervision time for HCAs primarily as a consequence of an increasing workload and a reduction in registered nurses. HCAs reported a sense of abandonment and isolation arising from the lack of guardianship provided by registered nurses. Current Government policy states targets to increase the numbers of HCAs employed in the Irish Public Healthcare system and encourages labour substitution (HSE, 2014a: 33). This policy direction is leading to registered nurses being increasingly replaced by HCAs with the consequence that there are a diminishing number of registered nurses to provide the necessary supervision to an increasing number of HCAs. Moreover, ongoing difficulties to recruit and retain registered nurses in the Irish health service have compounded the problem further (Aiken et al., 2013). In addition, as discussed earlier in this chapter, registered nurses are being challenged with other competing demands on their time such

as additional bureaucratic and administrative responsibilities, supervision of student nurses and expanding clinical roles. Confirming the findings of other commentators (Spilsbury and Meyer, 2005; Butler-Williams et al. 2010; Kessler et al, 2010; Hasson, McKenna and Keeney, 2012 and Cavendish, 2013) there is a growing hiatus between the nurse and the HCA, raising further questions about the registered nurses' ability to supervise and monitor care provided to patients by HCAs whilst the nurse is distant from the front line.

The risk presenting to patients living at home is seen to be higher as a consequence of the unique working conditions of the lone worker together with the absence of peer support and supervision (O'Shea, 2013). The findings from this study indicate that the registered professional cannot be assured that safe quality care will always be delivered by the delegated HCA in the absence of adequate supervision. The registered professional is therefore placing trust in the HCA that care interventions will be competently provided and the HCA will communicate back to the professional the outcome of those interventions. The data suggest that success of this arrangement is highly dependent on the relationship that exists between HCAs and their supervisors which may not always be conducive to effective dialogue. This means that open and constructive exchange of information may not always be forthcoming thereby raising further issues about registered professionals' ability to supervise and monitor the care provided to patients by HCAs. The concerns being raised in this study reflect the findings of the Áras Attracta Swinford Review Group that claim that the lack of supervision of care staff in Aras Attracta contributed to the circumstances in which vulnerable residents with an intellectual disability were recently abused (HSE, 2016). The present findings, therefore, suggest that restricted supervision for HCAs is an ongoing reality in the Irish health service and a risk to quality and patient safety.

Closely associated with supervision, the findings from this study also suggest that there are inconsistencies and uncertainties attached to the practice of delegation both on the part of the HCAs and the registered nurses which may ultimately compromise patient safety. Research evidence points to poor patient outcomes and incidents of missed care as a consequence of ineffective delegation practices between registered nurse and HCA (Kalisch et al, 2009). In this study, HCAs expressed a sense of frustration with conflicting instructions and subsequent criticisms directed at them by different registered nurses resulting in confusion. Furthermore, inherent in this confusion is a perceived lack of leadership and direction on the part of the younger inexperienced nurses who are hesitant

about delegating nursing tasks to unregulated assistant staff. This view is echoed by Shannon (2012) who finds evidence that the process of delegation from nurse to HCA is confusing and is compounded by the indistinguishable roles and responsibilities of both registered nurses and HCAs in acute hospitals in Ireland. The author concludes by declaring that the competence of HCAs in Ireland needs to be reassessed, together with ongoing monitoring and supervision of their work to enhance their contribution to care and ultimately quality outcomes. In a further Irish study McLoughlin (2014) revealed that HCAs were being delegated the tasks of taking patients' vital signs when it was inconsistent with local delegation policy.

In concurrence with the above sentiments, senior manager participants in this study suggest that there is still a '*fear of delegating from the nurses' perspective*'. The same managers propose that the competency and confidence associated with the art of delegation is variable and dependant on the individual registered nurse as well as the specific nature of the intended delegated task. Some difficulties with delegating tasks arise from a lack of education and training for registered nurses and a subsequent lack of clarity in the roles of HCAs (Centre for Allied Health Evidence, 2006; Alcorn and Topping, 2009; Hasson, McKenna and Keeney, 2013).

Identical issues were identified in 2006 shortly after the introduction of the HCA programme in Ireland. Consequently, to enable explicit task delegation, an educational awareness programme for nursing staff was made available nationally through the health service education centres (HSE, 2006). The purpose of the programme was to understand the principles of HCA training; appreciate the changing role of the healthcare assistant; and increase the qualified nurses'/midwives' knowledge and awareness of accountability in relation to delegation and supervision of healthcare assistants. It is therefore disappointing that despite this investment in training, nurses remain unclear about the process of delegation with the consequence that HCAs have tasks inappropriately assigned to them.

Furthermore, in this study, some HCAs observe that poorer delegation practices could be attributed to the less experienced nurse. This finding mirrors that of Hasson et al. (2013) who reported that newly qualified nurses were poorly prepared for the realities of supervision and delegation practices. The ambiguity associated with the act of delegating tasks from registered nurse to HCA is not new (Shannon, 2012) but nevertheless is disconcerting and poses a risk to positive outcomes of care.

A further factor identified by senior managers, supporting earlier discussion, was that the absence of clear requirements and standards for the training and practice in respect of HCAs leads to confusion in delegation. Senior managers make comparisons to student nurses and registered nurses who are guided by standards of practice established by the regulatory authority.

Closely associated with delegation are issues of accountability and the findings from this study point to uncertainty and concerns with accountability at the interface between HCAs and registered nurses for delegated tasks. In its most recent edition of the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives, the Nursing and Midwifery Board of Ireland (2014) is unambiguous in declaring that nurses are accountable if they make a decision to delegate a nursing task to someone who is not a registered nurse. Research participants in this study suggest that registered nurses are fearful to pass on responsibilities to HCAs as they are concerned that the accountability remains with them if something were to go wrong. This view is similar to those expressed by British Association of Critical Care Nurses (2003), Bosley and Dale (2008) and Fealy et al. (2014). In fact Fealy et al. (2014) revealed that accountability for delegation of nursing roles and tasks to unregulated care staff represented a particular concern for registered nurses. The uncertain qualifications and questionable skill sets of some HCAs only adds to these concerns. As a consequence of the mix of qualified, partially qualified and unqualified HCA staff working together and reports of variable standards of HCA training, registered nurses are reported in this study to be unclear about the distinction in knowledge and competencies between the qualified and non qualified HCA. Registered nurses are therefore understandably challenged to assure themselves and the public that the unregulated HCA has the appropriate level of knowledge and competence to undertake the delegated role safely (Cavendish, 2013; Fealy et al., 2014; McLoughlin, 2014) as demanded by the nursing regulatory body of Ireland:

Nurses and midwives are professionally responsible and accountable for their practice, attitudes and actions, including inactions and omissions. The nurse or midwife who is delegating (the delegator) is accountable for the decision to delegate. This means that the delegator is accountable for ensuring that the delegated role or activity is appropriate to the level of competence of the student or the regulated or unregulated HCW to perform (NMBI, 2015: 22).

This is an important finding as it points to concerns that registered staff will remain reluctant to delegate progressive work and tasks to unregulated HCA staff which will impede progression for this group and create tensions at the interface between HCAs and registered nurses.

In support of these claims a number of authors have called for the regulation of HCAs as a means of clarifying the situation by standardising training and introducing professional accountability for HCAs thereby protecting the public and by extension the delegating nurse and employing healthcare organisation (British Association of Critical Care Nurses, 2003; Bosley and Dale, 2008; Alcorn and Topping, 2009).

A key instrument of professional regulation is a code of professional conduct that describes the standards of conduct, behaviour and attitude that the public and people who use health and care services should expect from a HCA (Skills for Care and Skills for Health, 2013). The code should assure patients and the public that they will be treated by HCA staff who will exhibit the core values of caring, compassion and commitment at all times as outlined by the Department of Health, Ireland (2016b). Furthermore, a code of professional conduct will also assist employers and managers to understand what standards to expect of HCAs and to identify the requisite supports when HCAs fail to meet the required standards. Such codes have recently been introduced for HCAs in Scotland (Birch and Martin, 2009) and England (Cavendish, 2013).

6.6 Opinions on HCAs accessing patient information

As discussed earlier in this chapter, due to the increasing direct care nature of the HCA role together with the expanding administrative burden on registered nurses, HCAs have become the predominant front line carer. Consequently, HCAs have the opportunity to cultivate closer relationships with patients than nurses do and therefore gather useful information about patients. Hence, HCAs are often the predominant recipient of important information regarding change in patient health status as a consequence of the greater time spent with patients (Spilsbury and Meyer 2004, Kessler et al 2010). It is not unreasonable therefore to presuppose that other professionals such as registered nurses would seek and value this rich source of timely information from HCAs in respect of patient care and include them in the clinical handover process. However, the findings from this study indicate that this is not always the case. The findings reveal widespread disparity in the

value placed on the information and intelligence accrued by HCAs in respect of the clinical status of patients. Whilst some HCAs reported positive experiences of actively participating in handovers between working shifts, others felt more excluded from these forums citing examples of registered nurses closing the office door as an unambiguous message that the HCA is not welcomed at the handover. This exclusion of HCAs from patient handovers is considered by the UK Royal College of Nursing to be compromising patient care (RCN, 2014). In Ireland, Talty (2013) reported that the active inclusion of HCAs in the shift handover is a vital part of the overall integration of the HCA into the care team. Regrettably, she revealed that HCAs are not readily included in this process with the consequence that HCAs are regularly providing direct patient care bereft of the knowledge of the patient's condition.

Whilst the findings from this study concur with Talty's viewpoint, HCAs also claim that to compensate for their absence from the handover meetings, they would receive '*second hand*' reports from registered nurses following the formal clinical handover. However, these reports contain only scant information from the registered nurse that is perceived to be inadequate to meet the holistic care requirements of patients. The significance of handover cannot be overlooked and is a critical part of how all healthcare practitioners communicate. This practice of HCAs receiving a second hand report from registered nurses is perceived in this study to create needless duplication and inevitably results in disjointed care.

The level of HCA input to clinical handovers appears to be influenced by local leadership, workload and other circumstantial factors such as staffing levels. One senior nurse manager in this study acknowledges that HCAs do not always form part of the clinical handover team in her location and points to a workforce design challenge whereby HCAs are required on the clinical floor to maintain a safe environment while the registered midwives receive the formal handover. However, the literature challenges this practice and claims that virtually all aspects of care can wait for 30 minutes to ensure that staff are allowed to attend handover meetings subject to emergency cover being defined (see for example Australian Medical Association, 2006).

The findings from this study also reveal that HCAs experience disparity in the levels of access they have to patient records in comparison to their professional colleagues. Whilst some HCAs have reported that they have complete access to the clinical records of patients

that they care for, others have revealed a more restricted form of access whereby patient information is limited to personal details and any known risks associated with the patient's condition such as the risk of falls. A consequence of this restricted access is information asymmetry, whereby there are variations in the information possessed by different healthcare practitioners (see Arrow, 1963). Though most research participants support HCAs having full access to patients' clinical records a few HCAs and the service user representative expressed reservations and unease about this level of access. These concerns are placed in the context of small Irish rural communities where it can be difficult to maintain a sense of privacy and confidentiality because both staff and patients are known to one another. These findings have found an echo with studies from other jurisdictions whereby confidentiality can be compromised by existing local knowledge and relationships in small rural communities (Simon and Williams, 1999; Pugh, 2007). In contrast, confidentiality in large urban areas is facilitated by the relative anonymity of the larger populations they contain (Pugh, 2007).

The service user representative in this study repeatedly expressed a sense of disempowerment and unease when entrusting assistant staff with such confidential information suggesting an inherent power imbalance develops within the relationship between the HCA and the service user which can increase the sense of vulnerability on the part of the consumer. This power imbalance in favour of the HCA is a consequence of their access to private information about the person in their care (see Nursing and Midwifery Board of Australia, 2010). The case for regulation is particularly apparent in unequal relationships where there is an '*asymmetry of information*' and thus a relative lack of knowledge on the part of the service user (Arrow, 1963). Public interest theorists point to the necessity for the professional regulation of healthcare practitioners to correct this power distortion thereby ensuring that healthcare professionals are of a sufficiently high standard to safeguard the public and reduce uncertainties in the mind of the patient (ibid:1963). In contrast the service user representative had no such concerns about registered nurses having unlimited access to patients' medical records implying that professional regulation may contribute to correcting this suggested power imbalance.

6.7 Perceived value of professional regulation for HCAs and the public

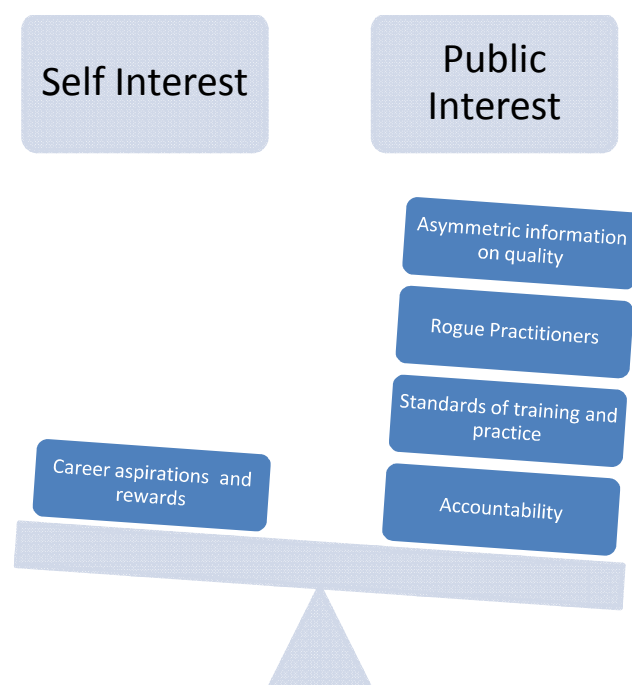
A particular focus of this study is to establish the desire for professional regulation among HCAs in respect of their occupational group. In doing so, the study also examines the extent to which HCAs seek out professional regulation in the interest of protecting the

public as espoused by the public interest theorists or alternatively motivated by self interest as posited by public choice scholars. Both will be discussed in the context of the findings. It is submitted that the current system of governance that underpins HCA practice is not proportionate and consistent with the risks posed to patients, and does not provide the public with the safeguards that they necessarily require (see also Saks and Allsop, 2007; Griffiths and Robinson, 2010; Duffield et al., 2014).

HCA participants in this study are unanimously in favour of some form of professional regulation for their occupational group. The HCA respondents acknowledge that some of their colleagues back in clinical practice may not support regulation but there is a sense of a growing momentum to be registered among assistants who occupy changing and dynamic roles. In further support of this claim, the national staff representative body for HCAs in Ireland, SIPTU are campaigning for the professionalisation of assistant staff. Furthermore, the recently established Alliance of Healthcare Assistants Ireland is also lobbying for the regulation of HCAs (see section 2.2.4). This finding is consistent with the UK where the British Journal of Healthcare Assistants poll of 385 staff found 93% backed compulsory registration (British Journal of Healthcare Assistants, 2013). Research respondents in this study and in particular HCAs revealed that desire for professional regulation of their occupational group is strongly motivated by sense of responsibility to protect the public. They point to public interest benefits such as traceability of rogue practitioners, consistency in standards of preparation and practice for HCAs, more accountability for their actions and ultimately greater confidence on the part of the public in HCAs as competent practitioners. From a self interest perspective HCAs view professional regulation as a vehicle to pursue viable career options within their own structure and significantly enhance the attractiveness of this role as a realistic career choice. However, the public interest rationale for extending regulation to HCAs outweighs any self interest motivational factors (see Figure 6-1 below). In fact, on reviewing the transcripts and the recordings of the focus group interviews with HCAs it was apparent that HCAs were acutely aware of their obligations to protect the public and that regulation could influence their practice to strengthen this protection. It should be noted, however, that these focus group interviews were undertaken at a period in time when there was heightened public awareness of severe shortfalls in standards of care and governance in some of the Irish health service hospitals and residential settings. The reporting of the scandals in Aras Attracta and in the Midland Regional Hospital Portlaoise were prominent

in all the focus groups and may have influenced the opinions of HCAs regarding their motivation for seeking professional regulation.

Figure 6-1 HCA drivers for professional regulation



6.7.1 Public Interest

The public interest theory of regulation contends that regulation is introduced to benefit and protect the public by intervening to correct inefficient or inequitable practices (Pigou, 1932). When inefficient or inequitable practices are uncovered a ‘market failure’ is said to be present suggesting the requirement of intervention in the form of regulation. This study reveals four possible sources of market failure associated with HCA practices as identified in Figure 6-1 above and will now be discussed further.

6.7.1.1 Asymmetric Information and Quality

Information asymmetry was discussed earlier with HCAs reporting restricted access to patient information and clinical handovers compared to other healthcare practitioners. It is also suggested in this study that some patients may have difficulty in determining the quality of the care interventions being offered by HCAs due to the relative lack of knowledge on the part of the service user. Consequently there is a risk that the unregulated healthcare practitioner will allow the quality of this service to deteriorate, since consumers

are unable to detect the difference (Cox and Foster, 1990). Therefore, this asymmetric information on the quality of the practice represents a potential market failure that uncorrected results in poor outcomes of care for the service user. Research respondents in this study make reference to healthcare scandals in the UK (Winterbourne View and Mid-Staffordshire) and Ireland (Aras Attracta) where appalling standards of care were administered by unregulated staff members to vulnerable adults who may not have possessed the requisite knowledge or abilities to determine or articulate the substandard quality of care received. Public interest theorists therefore point to the necessity of regulation as a deterrent to the provision of substandard quality of care (see Arrow, 1963; Graddy, 1991; Garoupa, 2006).

6.7.1.2 Rogue Practitioners

A further market failure identified by research participants in this study is the existence of HCAs with poor care practices. HCA participants were emphatically in favour of some form of regulation that would filter those who were genuinely interested in caring from those rogue practitioners who were primarily motivated by other factors such as money. Furthermore, the findings suggest that the entry level qualification for HCAs was set too low and therefore would continue to attract the interest of charlatans. However, this finding contradicts previous research undertaken in Ireland that reported satisfaction with the level 5 HCA training (Keeney et al., 2005). The authors sought the views of the managers of healthcare agencies who perceived the level of the training to be sufficient and indicated that they would employ trained HCAs in their organisations. Such differences may be explained by the earlier discussion that the role of the HCA has evolved and in some cases expanded since its introduction to the Irish health service and therefore the entry level qualifications may require revising to meet the additional demands of the role.

A further finding from this study points to the current lack of traceability of unregulated healthcare employees whereby HCAs dismissed from their work can commence employment in another similar setting shortly afterwards. In fact, one senior manager reveals his own personal experience of this loophole and relied on the goodwill that existed between employing organisations to share intelligence on exiting employees in the public interest. This finding confirms previous concerns raised by other authors regarding people who have gained employment as a HCA following dismissal from a previous healthcare post for misconduct (McKenna et al., 2004; Griffiths and Robinson, 2010). Consequently, HCA respondents from this study have called for the introduction of a central repository or

national register, a key feature of professional regulation that would record details of HCAs including qualifications and any sanctions applied to their practice and thus help combat the risk of employing rogue practitioners. Such a register would be readily available electronically to employers and the public at large. There are however existing mechanisms available to healthcare employers that when used would alert a new employer to a HCA's criminal record, professional conduct and level of competence. These include the security vetting process which is completed by all new healthcare employees before they can practice with patients. Furthermore, professional reference checks are undertaken with past employers to eliminate any criminal history and check for overall suitability for the post. Finally, a medical clearance is obtained from the employee's general practitioner to assure the new employer of their health status and that they do not present a health risk to other employees or patients (see Griffiths and Robinson, 2010). Whilst these mechanisms have value, respondents in this study have concerns as to whether these checks and measures are consistently applied and robust enough to protect the public. For example, an employee may choose not to declare a past employer as a referee where they were subject to a charge of misconduct and therefore future employers would be oblivious to these past offences, thereby compromising patient and public safety. Similar concerns were echoed by Saks and Allsop (2007). In contrast, under a regulatory framework, any misdemeanours or misconduct on the part of the HCA will be recorded on a national occupational register together with any appropriate sanctions applied up to and including removal from practice. It is perceived by respondents in this study that this central regulatory control mechanism would facilitate transparency and traceability of HCA employees as they move between employers thereby reducing the risk to patient safety and the public at large.

6.7.1.3 Standards of Training and Practice

Another type of market failure identified in this study and therefore a driver for seeking regulation under the banner of public interest is the variability in the standards of training and practice associated with the HCA role. Whilst a nationally agreed programme exists for training of HCAs, there is no mandatory requirement for HCAs to attain any such qualifications. As a consequence, there is reported variability in the education and training received in preparation for the HCA role. Thus, although HCAs may have been prepared for their practice by credible and competent clinicians, the fact that their practice and education are not regulated means that consistency of standards cannot always be guaranteed (see section 5.3.1.1). This variability in the application of the nationally agreed

programme has resulted in a phenomenon where there now exists a three-tiered HCA workforce in the Irish healthcare service – fully qualified, partially qualified and unqualified. Such findings support previous international research (Willis, 2012; Francis, 2013; Cavendish, 2013; Duffield et al., 2014). In fact, with the increasing dependency on HCAs in the UK and reports that extensive substitution of registered nurses with unskilled HCAs has resulted in inadequate patient care, increased morbidity and mortality rates, and negative nurse outcomes, Duffield et al (2014) argue that it is timely to consider regulation of HCAs with their role and scope of practice clearly defined.

As reported earlier in this discussion, the fact that the practice of HCAs is not regulated in Ireland means that consistency of standards cannot always be guaranteed and consequently patients would be exposed to unnecessary and unjustifiable risk. At a minimum, the public needs to know that support workers are able to work safely, with the basic knowledge relevant to their job. *‘Beyond the minimum, the public expects workers to be competent. It expects – and deserves – workers to be kind, capable, and able to communicate clearly’* (Cavendish, 2013: 37).

This study has revealed an appetite for baseline educational standards of HCAs to be protected through regulation to safeguard consistency in practice. The rationale for this argument is that whilst the role of the HCA is changing, the qualifications of the regulated HCA could be certain, thereby giving the public the confidence that HCAs have been educated to the requisite level and are licensed to practise.

Central to the argument for regulating the practice of HCAs are repeated references to recent scandals in the Irish health service involving HCAs (see section 2.5.1). Many HCA and senior manager participants contend that such scandals are sufficient justification for the introduction of nationally agreed occupational standards underpinned by regulation for HCAs in Ireland. National Qualifications Ireland (2014: 4) define occupational standard as *‘a standard of knowledge, skill and competence that must be achieved to qualify or license a person to practise in a specific occupation’*. Furthermore, national occupational standards describe the minimum standard to which an individual is expected to work in a given occupation. The introduction of a framework of nationally accepted standards and associated competencies for HCAs would also clarify issues of responsibility, delegation, supervision and accountability (Skills for Care and Development, 2008). In support of an earlier discussion, this is currently a problem for registered nurses since they are regarded

as accountable for the work that they delegate to HCAs. Research participants felt that if the standards were not mandatory then the variable application of the standards nationally would prevail among employers and HCA employees.

On a related matter, this researcher is currently engaged in a European Union (EU) commissioned study to explore the interest among all Member States of the European Union in developing a common position on the knowledge, skills and competences of healthcare assistants (HCAs) in Europe. A key rationale for developing a common training framework (CTF) for HCAs across Europe is to facilitate cross-border mobility of HCAs while safeguarding patient safety. Early findings from the study suggest that there is a high willingness of Member States and European stakeholders to be involved in the exploration of a potential CTF for HCAs, however as yet there is no common position on making a formal suggestion to the European Commission. A final report on the findings of the study is due for publication at the end of 2016.

6.7.1.4 Accountability

The final source of market failure identified by research participants in this study and a key motivation for regulation is accountability. Earlier in this discussion chapter the uncertainties and concerns with accountability at the interface between HCAs and registered nurses for delegated tasks were explored. Of particular concern were fears on the part of registered nurses to pass on roles to HCAs in the absence of regulation as they are unsure of where the accountability lies if something were to go wrong. Recently, the Irish Nurses and Midwives Organisation (2016) called on the Irish Nursing and Midwifery regulatory Board to clarify the responsibility of the delegator and the specified accountability of the HCA in delivering care; such is the level of concern among its members. Storey (2002) held that HCAs are accountable to their employer through their contract of employment if they fail to deliver care to a level for which they have been prepared and assessed as competent, and legally accountable to the patient (if the law has been breached). However, HCAs cannot be professionally accountable as they are currently unregulated.

The findings from this study suggest that HCAs should be accountable for their own practice and professional regulation would provide this assurance. However, commentators are inconclusive on this finding. Whilst some support the concept that HCAs should be accountable for the care they deliver and, therefore, registered with a professional

regulatory body (Alcorn and Topping, 2009; Duffield et al., 2016), others are less amenable to this notion on the basis that there are complex differences between managing and supervising the care of patients and following directions of a regulated professional, and thus HCAs should continue to be accountable to a registered nurse (Youg, 2008; Bosley and Dale, 2008; Vaughan et al., 2014).

However, it is readily apparent from the findings that rather than seeking to abdicate responsibility when faced with the consequences of their actions, HCAs have clearly indicated readiness to accept responsibility and accountability for their practice. Senior managers in the main agree that the current situation is unsatisfactory and accountability of HCAs should be monitored through a regulatory body. However, registered nurses must continue to have supervisory responsibilities over the role of HCAs in the Irish health service (INMO, 2016).

The findings and motivations relating to self interest will now be discussed.

6.7.2 Self Interest

An opposing view to the public interest theory of regulation posited by the proponents of public choice is that *'regulation is supplied in response to the demands of interest groups struggling among themselves to maximise the incomes of their members'* (Posner, 1974: 335-336). In other words occupational groups pursue the attainment of regulation for self interest and abandon any notion that regulation is an instrument to pursue public interest.

From a self interest perspective the findings in this study suggest that HCAs view professional regulation as a vehicle to pursue viable career options within their own structure and significantly enhance the attractiveness of this role as realistic career choice as presented in Figure 6-1 above. While a HCA has limited opportunities to advance professionally it is primarily in the direction of entering the nursing. However, this study reveals that entering nursing is neither an option nor a desire for some HCAs, pointing to the incessant bureaucratic and administrative pressures that have now become evident with the registered nursing role. Instead, HCAs appear to value their front line responsibilities and their close proximity to the patient and therefore view regulation as an opportunity to build a career pathway within their own structure. These findings are echoed in a recent UK survey undertaken by UNISON, the public service union with sixty percent of 2,300 healthcare support workers surveyed claiming that that the opportunities to progress

beyond their current roles are inadequate (UNISON, 2016). However, other commentators recommend that HCA training should be inextricably linked to nurse training thereby providing the opportunity for both groups of staff to learn together and simultaneously creating a pathway into nursing for HCAs (Glasper, 2013; Cavendish, 2013).

The findings from this study suggest that if there was a recognised career structure and more opportunity then more people would be attracted to the role and remain in the role. Some HCA participants and senior managers made reference to a management pathway for assistants that would enhance career progression and reward for working as a HCA in Ireland. Whilst some colleges and higher education institutes (HEIs) in Ireland have developed an educational pathway for HCAs to move from the current level 5 QQI (FET) to level 6 and level 7, this is not mirrored by the existence of a parallel career pathway. Being kept at a single grade creates a situation where HCAs feel that there is a lack of career progression and reward for working as a HCA in Ireland.

In a development, the Department of Health in Ireland has recommended that:

...a national review of the education, role and functions of the nursing healthcare support worker roles, such as the Healthcare Assistant and Multi-task attendant is undertaken; and that the findings of this review will inform alterations to the nursing/healthcare assistant grade mix. (Department of Health, 2016a)

The terms of reference for this review have not yet been made available but it is suggested that an alternative grade of HCA in addition to the existing grade may be considered.

In summary, there is a consensus that HCA staff should be regulated as a single group and their motivation and desire is primarily driven by a sense of obligation to protect the public and that regulation could influence their practice to strengthen this protection. Some HCAs are motivated to seek regulation by self interest; however, this should not be overstated as the public interest rationale for extending regulation to HCAs outweighs any self interest motivational factors.

Although there was little consensus within the findings of this study about the most appropriate regulatory authority, it seems appropriate that any regulatory governance should rest within nursing. Some senior managers in this study argue that to select one of

the other regulators referred to in the findings such as CORU or PHECC would alienate the HCAs from the group they work with most closely.

However, whilst there was provision in the Nurses Act, 1985 in Ireland for the extension of professional regulation to other unregulated groups such as HCAs, this provision did not carry over into the new Nurses and Midwives Act, 2011. Therefore, to facilitate this process, amendments to the Act would be required. This decision will ultimately rest with the Department of Health.

HCA participants in this study revealed that regulation would bring added value in terms of training, standards of practice and competence assurance and therefore have stated their readiness in principle to pay to be professionally regulated. However, concerns were expressed that costs could be prohibitive with some of the proposed regulators as HCAs are on relatively low salaries compared with other professional groups in the healthcare workforce. Moreover, if HCAs perceive the cost of regulation to be excessive, then it may become less attractive for those considering a career as a HCA or lead to an increase in attrition from the existing HCA workforce (see section 5.6.3.2). This has prompted HCA respondents in the study to caution that any costs attributed to them for regulation needs to be fair and in accordance with their income and qualifications.

The list of fees, below in Table 6-1 highlights the discrepancy between the fees charged by the CORU, PHECC and the NMBI to their respective registrants.

Table 6-1 Fees charged by relevant regulatory authorities

Type of Fee	NMBI – 64,790 Registered Members	CORU – 20,000 Registered Members	PHECC – 4,666 Registered Members
Annual Retention Fee	Currently €100 but sought to increase to €150 in 2015	Currently €100 and to be reviewed at end of 2016	€10
Application Fee	€145 for new graduates (Irish trained only)	€100	€10
Recognition of professional qualifications obtained outside Ireland	€350	€410	€350

PHECC, which is the smallest of the three professional regulatory bodies, is the least expensive on the basis of annual retention fees charged to registrants. On the other hand, CORU charges the highest levy for administration relating to the recognition of overseas qualifications, whilst the NMBI is the most expensive for application fees. The picture is one of considerable variance in the fees charged to registrants for the same privilege of being regulated.

Though PHECC is certainly less prohibitive than the other regulators on the basis of cost, on deeper analysis HCAs would not meet the criteria to have their names entered on the PHECC register of practitioners as none of them are employed as pre-hospital emergency care practitioners and do not hold a National Qualification in Emergency Medical Technology (NQEMT).

6.8 Summary

This chapter opened with a reminder of the research project undertaken and recalled the aim and objectives of this case study. The chapter moved on to discuss the main factors arising from the findings that impact on the evolving role of the HCA and influence the decision in respect of any future professional regulation for HCAs in Ireland. The primary salient themes were examined in the broader context of the extant literature. The findings from my study appear to both support and challenge previous research. This study reveals inconsistencies in the utilisation and expansion of the role with the consequence that research participants are calling for nationally agreed standards of practice together with a universal job description. A significant finding from this study is the emergence of a three-tiered HCA workforce – qualified, partially qualified and unqualified - which is the source of confusion and tension with accountability at the interface between HCAs and registered nurses for delegated tasks. Perhaps the most significant outcome of my study is the reports of the practice of HCAs working alone, unsupervised with vulnerable patients in their own homes that appeared to be the source of greatest concern amongst the research participants. HCAs were also sometimes the subject of information asymmetry whereby they had less access to critical patient care information than their professional colleagues.

The next chapter will present the main conclusions, implications and recommendations stemming from this research.

Chapter 7 Conclusion and Recommendations

7.1 Introduction

In this chapter I offer conclusions, recommendations and personal reflections on the experience of undertaking the research.

7.2 Recommendations

Based on the findings of this research, the following recommendations are proposed together with the relevant rationale.

7.2.1: Overarching Recommendation

It is recommended that all health care assistants employed in both the public and private healthcare sector and administering care under the governance of nurses and midwives are considered for registration with a professional regulatory body in the public interest. The principles of Right-touch regulation should be considered to determine the extent of regulation required. It is acknowledged that such a decision would rest with the Department of Health.

Rationale: The findings from this study point to a number of risks to the public associated with the evolving HCA workforce continuing to provide front line clinical care while unregulated. These include;

- variability in the standards of training and practice associated with the HCA role,
- confused accountability at the interface between HCAs and registered nurses for delegated tasks,
- unsupervised practice,
- homecare support workers,
- lack of traceability of unregistered HCAs and

- concerns regarding difficulties that some patients may experience in determining the quality of the care interventions being offered by HCAs.

The remainder of the recommendations are now proposed in respect of each of the above risks together with the relevant rationales.

7.2.2: Variability in the standards of training and practice associated with the changing HCA role

1. *It is recommended that all employers in both public and private health care agencies require that all healthcare assistants administering care under the governance of nursing are trained to QQI (FET) Level 5 Certificate in Health Service Skills appropriate to their clinical area of practice. Furthermore, no HCA should administer care unsupervised until they had successfully completed this training.*

Rationale: The findings from this study point to a three-tiered HCA workforce that creates confusion and tension in the delegation of tasks at the interface between the registered nurse and the HCA (see section 6.4).

2. *It is recommended that consideration should be given to the development of a mandatory nationally agreed minimum standards framework for education and training of HCAs by the appointed regulatory body.*

Rationale: The findings from this study suggest that a theory practice divide exists in respect of the HCA training. Research participants reported examples of classroom theory from the programme not reflecting the realities that HCAs face the clinical workplace (see section 6.4). A standards framework will inform education providers on appropriate curriculum in respect of HCA training. Additionally, this framework will also serve as a source of reference for employers and supervisors to clarify education and competency levels of HCAs. Consequently, the registered nurse will be better informed to assess the appropriateness of delegating certain tasks whilst also giving the public the confidence that HCAs have been educated to the requisite level. The nationally agreed minimum education standards need to be accompanied by national occupational standards for practice with the former mapped against the latter.

3. *It is recommended that consideration should be given to the introduction of nationally agreed occupational standards for HCAs by the appointed regulatory body.*

Rationale: The findings from this study indicate that the work practices of HCAs are variable and context specific. Consequently, consistency of standards cannot always be guaranteed and therefore patients could be exposed to unnecessary and unjustifiable risk (see sections 6.3 and 6.7.1.3). National Qualifications Ireland (2014: 4) define occupational standard as ‘*a standard of knowledge, skill and competence that must be achieved to qualify or license a person to practise in a specific occupation*’. Furthermore, national occupational standards describe the minimum standard to which an individual is expected to work in a given occupation. The introduction of a framework of nationally accepted standards and associated competencies for HCAs would also help to clarify issues of responsibility, delegation, supervision and accountability. In support of another finding, this is currently a problem for registered nurses since they are regarded as accountable for the work that they delegate to HCAs. The national occupational standards for practice need to be accompanied by the mandatory nationally agreed minimum education standards as per previous recommendation with the latter mapped against the former.

4. *It is recommended that the appointed regulatory body should issue HCAs with a scope of practice framework. The framework should define the range of roles, functions, responsibilities and activities which the HCAs have the authority to perform and determine their education and competence.*

Rationale: The findings from this study suggest that as a consequence of the changing dynamics of their role, HCAs are expected to work beyond their scope of competence in support of registered nurses. As such, there is a sense that there is an over-reliance on the role. Incidents of HCAs working beyond their boundaries of practice usually occurred in the context of staff shortages and increasing workload pressures (see section 6.3). A scope of practice framework would offer clarity and reaffirm the safe boundaries of practice for HCAs and the delegating professional.

5. *It is recommended that all employers in both public and private health care agencies clearly delineate the HCA role through a revised national standardised*

job description, informed by a legally defined scope of practice and nationally agreed occupational standards as outlined above.

Rationale: A repeated theme emerging from the findings of this study is that a source of concern for HCAs, and perceived to be a significant contributor to the inconsistent deployment of HCA skills, is the absence of an unambiguous job description or job profile detailing the tasks, responsibilities and scope of the HCA role. The findings from this study illuminated the inconsistent and ‘muddled’ job description that supports the role of the HCA and subsequently has contributed to the confusion between related roles such as multi-task attendants (MTAs) (see section 6.3).

7.2.3: Confused accountability at the interface between HCAs and registered nurses for delegated tasks

- 1. It is recommended that all employers in both public and private health care agencies provide the opportunity for registered nurses to undertake an educational awareness programme for nursing staff to: understand the principles of HCA training; appreciate the role of the healthcare assistant; and increase the qualified nurses’ knowledge and awareness of accountability in relation to delegation and supervision of healthcare assistants.*

Rationale: The finding from this study point to ongoing ambiguity associated with the act of delegating tasks from registered nurse to HCA and poses a risk to positive outcomes of care. Senior manager participants in this study suggest that there is still a ‘fear of delegating from the nurses’ perspective’, while some HCAs observe that poorer delegation practices could be attributed to the less experienced nurse (see section 6.5).

7.2.4 Unsupervised practice

- 1. It is recommended that a review of supervision arrangements for HCAs should be undertaken by healthcare employers.*

Rationale: The findings from this study suggest that restricted supervision for HCAs is an ongoing reality in the Irish health service and a risk to quality and patient safety. Research

participants reported ongoing diminution of supervision time for HCAs primarily as a consequence of an increasing workload and a reduction in registered nurses. Furthermore reports from the research suggest that registered nurses are being challenged with other competing demands on their time such as additional bureaucratic and administrative responsibilities, supervision of student nurses and expanding clinical roles. Thus, a growing hiatus between the nurse and the HCA is raising further questions about the registered nurses' ability to supervise and monitor care provided to patients by HCAs whilst the nurse is distant from the front line (see section 6.5).

7.2.5 Homecare Support Workers

- 1. It is recommended that HCAs working as homecare support workers should be prioritised for consideration for registration with a professional regulatory body in the public interest. Furthermore, the recommendations from the Law Reform Commission (2011) that the Health Information and Quality Authority (HIQA) should be given additional regulatory and inspection powers to regulate and monitor the undertakings of domiciliary care providers should be progressed.*

Rationale: The findings from this study indicate that the practice of HCAs working alone, unsupervised with vulnerable patients in their own homes, is having its own unique set of risks both for the employee and the patient. Both parties are being left exposed and vulnerable to varying accusations such as abuse, violence or other forms of criminality (HSE, 2012). Research has shown that risks are known to be magnified when procedures are carried out in less controlled settings, such as in patients' homes (O'Shea, 2013) (see section 6.5).

7.2.6 Lack of Traceability of unregistered HCAs

- 1. It is recommended that the appointed regulatory body should consider the introduction of a central repository or national occupational register, a key feature of professional regulation that would record details of HCAs who meet all of the aforementioned standards and any sanctions applied to their practice and thus help combat the risk of employing rogue practitioners.*

Rationale: The findings from this study point to the current lack of traceability of unregulated healthcare employees thus HCAs dismissed from their work can commence

employment in another similar setting shortly afterwards. In fact, one senior manager revealed his own personal experience of this loophole and relied on the goodwill that existed between employing organisations to share intelligence on exiting employees in the public interest. This finding confirms previous concerns raised by other authors regarding people who have gained employment as a HCA following dismissal from a previous healthcare post for misconduct (McKenna, Hasson and Keeney, 2004 and Griffiths and Robinson, 2010) (see section 6.7.1.2). Furthermore, little is known about HCAs in Ireland in terms of workforce numbers, demographics and qualifications. As long as this is the case, healthcare policy makers and employers will be limited in their ability to develop and implement feasible, effective integrated workforce plans. Literature recommends that healthcare systems collect and use HCA data in workforce planning and therefore necessitates the introduction of national registers for HCAs in each country (Hewko, 2015).

7.2.7: Concerns regarding difficulties that some patients may experience in determining the quality of the care interventions being offered by HCAs.

1. *It is recommended that the appointed regulatory body should consider the introduction of a code of conduct and ethics for HCAs.*

Rationale: The findings from this study suggest that some patients may have difficulty in determining the quality of the care interventions being offered by HCAs due to the relative lack of knowledge on the part of the service user. Consequently there is a risk that the unregulated healthcare practitioner will allow the quality of the service to deteriorate, since consumers are unable to detect the difference (Cox and Foster, 1990). Hence, the public interest theory asserts that rigid and restricted entry requirements to healthcare professions through regulation corrects this market distortion by ensuring that healthcare professionals are of a sufficiently high standard to safeguard the public and reduce uncertainties in the mind of the patient (Arrow, 1963) (see section 6.7.1.1).

7.3 Summary of the contribution to knowledge

A growing body of literature points to the significant benefits of professional regulation for HCAs in the public interest (Griffiths and Robinson, 2010; Francis et al., 2013; Duffield et al., 2014; Hewko et al., 2015; Royal College of Nursing, 2015). Despite this, there is a dearth of empirical research exploring this area of interest (Saks and Allsop, 2007) and

what exists generally focuses on education and training of HCAs. Furthermore, the majority of the literature pertaining to regulation of HCAs is limited to systematic reviews or commentary in nature. This lack of literature pertaining to HCA roles particularly in relation to professional regulation in Ireland demonstrates a limited consideration regarding the value of this workforce and therefore was viewed as an area for further investigation in this study. While the literature review attached to this study is not an exhaustive list of empirical research that has been undertaken, it is nonetheless comprehensive and points to the need for a larger evidence base regarding the professional regulation of HCAs, especially in the Irish context.

This study adds knowledge through an in-depth exploration of the views of HCAs in respect of professional regulation of their roles. This is the first major study involving HCAs and this subject matter in Ireland. This study also seeks for the first time the views of senior managers, policy makers, trade union leaders, educationalists, and service user representative in respect of the HCA role in Ireland.

This study has also contributed to this knowledge void by uncovering knowledge of the HCA in relation to role preparation, career aspirations and asymmetric information.

This study has discovered that the failure in policy to mandate the entry level training for all HCAs when introduced to the Irish health service in 2001 has resulted in a unique three-tiered workforce; qualified, partially qualified and unqualified. Educational disparity between HCAs has the potential to be a source of confusion for registered nurses who may be unclear about the distinction in knowledge and competencies between the qualified and non qualified HCA.

Employing the contrasting theories of public interest and public choice, this study also elucidates the motivation of HCAs to seek regulation. It emerges that their motivation and desire is primarily driven by a sense of obligation to protect the public interest and that regulation could influence their practice to strengthen this protection. One of the factors to seek regulation viewed through the paradigm of public choice and self interest for HCAs is to pursue viable career options within their own structure and significantly enhance the attractiveness of this role as realistic career choice. This is a surprising finding as current literature and policy internationally promotes pathways for HCAs into nursing. A final contribution to knowledge relates to the concept of asymmetry of information. This study

has revealed that the phenomenon of small rural communities and the subsequent difficulties of maintaining a sense of privacy and confidentiality can be a source of unease and discomfort for unregulated HCAs and service users. Thus, some unregulated HCAs choose to avoid accessing clinical information that may be critical for the administration of care. I am not aware of any other studies that have investigated this phenomenon involving unregulated HCAs.

7.4 Summary of the contribution to practice

This study makes a significant contribution to practice by uncovering for the first time the primary risks associated with the role of the unregulated HCA in the Irish health service. The principal risks are identified in section 6.2.1 of this chapter. A significant risk identified in this study and which is a source of concern for all research participants is the practice of HCAs working alone, unsupervised with vulnerable patients in their own homes. This model of care delivery is viewed as having its own unique set of risks both for the employee and the patient.

This study has set out the recommendations for policy and service delivery to address all of the primary risks identified in the research. The recommendations of this study are timely as they will inform and contribute to other policy reviews in respect of the HCA role in Ireland. These include:

- National review of role and function of HCA (Health Service Executive);
- A scoping exercise with a view to undertaking a HCA role review including standardisation of job descriptions, clarity of roles and responsibilities and current development pathways with proposals to improve these pathways (HSE HR Education);
- A Report on Perinatal deaths in HSE Midland Regional Hospital Portlaoise recommended a review take place to examine the potential for a role for maternity care assistant (Office of the Nursing and Midwifery Services Director);
- An examination of the potential benefits for the introduction of theatre assistants (HR Manager, National Acute Hospitals Division).

Furthermore, I am currently the Irish representative on a European Union (EU) commissioned study to explore the interest among all Member States of the European Union in developing a common position on the knowledge, skills and competences of healthcare assistants (HCAs) in Europe. A key rationale for developing a common training framework (CTF) for HCAs across Europe is to facilitate cross-border mobility of HCAs while safeguarding patient safety. This research will better inform my contribution to the EU study.

7.5 Limitations

The strengths and limitations of the case study approach were openly acknowledged in section 4.5.3 of this thesis. I used ‘thick descriptions’ (see Stake, 1998) in the interpretation of the data to enable the findings to have resonance with the reader to relate to particular elements within the findings or make comparisons between findings and other research fields. However, the findings did reflect those of international studies in the field thus providing a degree of confidence in the results.

This study considered the views of stakeholders who constituted the most important targets for the primary research conducted as part of this study. Within the timeframe only one service user representative was successfully recruited to seek views in respect of HCA regulation. This could be seen as a possible shortcoming of the research as more service user representatives may have provided an alternative perspective and added richness to the findings.

A further limitation of the sample was the views of the registered nursing staff that were outside this study’s remit. Obtaining such perceptions may have provided a broader or different perspective. However, I decided not to include them as their views were sought in a previous evaluative study in 2005 following the introduction of the HCA training programme. However, despite the limitations of the sample, their views are supported by the responses from the nurse managers in the study as well as the national and international literature on the topic.

7.6 Direction of future research

This study has highlighted a number of areas where further research is required, particularly as this is an under-developed area for policy makers in Ireland.

Whilst this study considered the possible selection of regulators should a policy decision be reached to extend regulation to HCAs, further more detailed research may be required to explore the options with the existing regulatory bodies.

Also, an appropriate regulatory model proportionate to the risks presented by the HCA workforce needs to be considered. One such concept introduced by the Professional Standards Authority (PSA) in the UK that is already gaining traction is Right-touch regulation (PSA, 2015). This approach seeks to ensure that an acceptable balance is achieved between the two extremes of over-regulation on the one hand and under-regulation on the other (CHRE, 2010). This could perhaps provide a focus for future research on this topic. Another area that merits further investigation is the potential impact of the regulation of the HCA workforce on the recruitment and retention of its members.

Finally, given the legitimate concerns raised in this study, I believe the role of the homecare HCA should be the subject of further research with a focus on the support for the role as well as the impact of the role.

7.7 Self Reflection

This section includes some reflections in the broader sense, such as my own personal development, the choice of research area and aims, the methods I employed and my personal views on the HCA workforce that I had the privilege to study.

This research work has contributed greatly to my professional development. As an Area Director of Planning and Development for Nursing and Midwifery, I regularly engage with Heads of Departments and lecturers in universities and other higher education institutes. The programme has greatly enhanced my confidence and competence in my interactions with these stakeholders through better awareness of research. Furthermore, my writing skills have continued to improve and my ideas are presented more clearly and concisely without ambiguity.

I believe my role as Area Director was an enabler for me to gain access to the research participants, particularly the range of key stakeholders that were critical to the study. I have noted my concerns in the methodology design regarding accessing the HCAs for the focus groups and how I managed the perception of 'power and control'.

Both the case study approach and the template analysis were appropriate for an in-depth explorative study. However, I was challenged by the quantity of data that was generated with the consequence that my manuscripts required significant editing to comply with the limit of my allocated word count.

Since commencing the DBA, I have been invited to participate and present at forums in Ireland and internationally. I have given updates in respect of my research findings to several national interest groups in Ireland. Furthermore, I was invited to present a poster at the World Health Professional Regulation Conference in Geneva, May 2016. As previously referenced in this thesis, I have also attended a European Commission forum in Brussels as an expert relating to healthcare assistants to explore the feasibility of a common training framework for HCAs in the EU.

Finally, it was a great privilege to undertake this research with a workforce that, because of their unregulated status, can be invisible to researchers, management and the general public. Along this journey I have met many dedicated and passionate HCAs full of caring, compassion and commitment. Despite the unanticipated challenges I encountered throughout the study my interactions with these practitioners have proved to be an enormously worthwhile personal experience. Overall, this DBA has resulted in very significant learning and skills development, but most importantly, this study contributes new knowledge and understanding of the value of the HCA workforce in the Irish healthcare system.

7.8 Summary

This chapter concludes the thesis. The chapter has proposed the recommendations arising from the findings of the study together with the relevant rationales. The chapter has also identified the study's contribution to knowledge and practice. The research has contributed to knowledge in the areas of role preparation, career aspirations and asymmetric information. The contribution to practice was achieved by setting out for the first time the primary risks associated with the role of the unregulated HCA in the Irish health service. The research outcomes will also contribute to related reviews occurring in Ireland and Europe. The chapter concluded by identifying the limitations of this study, suggesting future areas of research and offering a personal reflection of the journey.

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Appendix 1 Reports on adverse events in the Irish health system in recent years

Date	Report
December 2002	Review of a clinical adverse event, in which a pregnant patient attended Monaghan General Hospital and was transferred to Cavan General Hospital. Delivery of a pre-term infant occurred during transfer and the infant subsequently died at Cavan General Hospital.
December 2001	Report of the Independent Review Panel to the Minister for Health and Children concerning the birth of Baby Bronagh Livingstone.
July 2003	Report of the Panel reviewing the events surrounding the death of Roisin Ruddle.
February 2004	Report into the circumstances pertaining to the death of Frances Sheridan.
October 2005	Report into the death of Patrick J Walsh.
2006	Report of Judge Maureen Harding Clark S.C. following the Inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda.
August 2007	Report into the circumstances that led to the decision by the HSE to suspend breast radiology services, initiate a clinical review of symptomatic breast radiology services and place a consultant radiologist on administrative leave at the Midland Regional Hospital, Portlaoise.
August 2007	Report of the Independent review of Symptomatic Breast Care Services at Barringtons Hospital, Limerick.
February 2008	Management, governance and communications issues arising from the review of breast radiology services at the Midland Regional Hospital, Portlaoise.
April 2008	Report of the HIQA investigation into the circumstances surrounding the provision of care to Rebecca O'Malley, in relation to her symptomatic breast disease, the Pathology Services at Cork University Hospital and Symptomatic Breast Disease Services at the Mid Western Regional Hospital, Limerick.
June 2009	The Leas Cross Commission The Commission of Investigation (Leas Cross Nursing Home) Final Report June 2009.
May 2012	Tallaght Hospital Investigation Report.
October 2013	Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital Galway, and as reflected in the care and treatment provided to Savita Halappanavar.
February 2014	HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date).
July 2016	Report of the Áras Attracta Swinford Review Group.

Appendix 2 Recruitment letter sent to focus group participants



Title-Name

Address I

Address2

Address 3

Address4

Date:

Re: An Examination of the Requirement and Extent for Professional Regulation of Healthcare Assistants in the Republic of Ireland.

Dear

I am currently enrolled as a Research Student at the Newcastle Business School in Northumbria University, England. In fulfilment of the research requirements, I am undertaking research into the above theme.

Recent years have seen a growing emphasis on regulation and inspection in Ireland with a stronger focus on public protection. The introduction of the Health and Social Care Professionals Act (2005) and the Nurses and Midwives Act (2011), as well as the establishment of the Health Information and Quality Authority (2007) are evidence of a shift towards greater regulation.

Healthcare assistants represent an important and increasingly substantial proportion of the Irish healthcare workforce, with a total of 14,500 currently employed in the public sector. However, the growth of the role has taken place without regulation.

I would like to invite you to participate in this research. In particular I would like to invite you to agree to participate in a focus group, which will be one of three conducted nationally. The focus group will take about one hour. I am attaching an information sheet that contains a more detailed description of what is involved.

The focus group, to be held on Thursday 11th June, will include 9 other participants who work as healthcare assistants in the Irish Health service. I will also be accompanied by, Specialist Co-ordinator at the Centre of Nursing and Midwifery Education, During this Focus Group meeting, you will have the opportunity to share your experiences with and thoughts about your role as a healthcare assistant and why the role should or should not be subject to regulation in the future.

As a participant in the Focus Group, your views and experiences are extremely valuable in helping to establish if regulation of your role would enhance patient safety and quality of care.

The focus group will be held on Thursday 11th June at 2pm in Room 1A, Academic Centre, Connolly Hospital, Blanchardstown. Refreshments will be provided.

Although we hope you will join us, participation is voluntary. Please be assured that anything you say during the focus group will be kept strictly confidential, and will not release any information that can be linked to you.

Thank you for your cooperation. I am sure you understand the importance of the theme being addressed. Your particular contribution will be highly valuable and significant to the value of the findings.

If you require any further information or have any questions you can contact me on 086 8157296.

Yours sincerely

Patrick Glackin
DBA Student/ Researcher

Appendix 3 Recruitment letter sent to semi-structured in-depth interview participants



Title-Name

Address I

Address2

Address 3

Address4

Date:

Re: An Examination of the Requirement and Extent for Professional Regulation of Healthcare Assistants in the Republic of Ireland.

Dear

I am currently enrolled as a Research Student at the Newcastle Business School in Northumbria University, England. In fulfilment of the research requirements, I am undertaking research into the above theme.

Recent years have seen a growing emphasis on regulation and inspection in Ireland with a stronger focus on public protection. The introduction of the Health and Social Care Professionals Act (2005) and the Nurses and Midwives Act (2011), as well as the establishment of the Health Information and Quality Authority (2007) are evidence of a shift towards greater regulation.

Healthcare assistants represent an important and increasingly substantial proportion of the Irish healthcare workforce; however, the growth of the role has taken place without regulation.

I would like to invite you as a key stakeholder to participate in this research. In particular I would like to invite you to agree to participate in a semi-structure in-depth interview. The interview will take about 45 minutes. I am attaching an information sheet that contains a more detailed description of what is involved.

The interview will be held on XXXXX **2015** and you will have the opportunity to share your experiences and thoughts about the role of healthcare assistant and why the role should or should not be subject to regulation in the future.

As a participant in this research, your views and experiences are extremely valuable in helping to establish if regulation of this role would enhance patient safety and quality of care.

The interview is scheduled for day and date **2015 at (Time) Name of location.**

Participation is voluntary and please be assured that anything you say during the interview will be kept strictly confidential.

Thank you for your cooperation. I am sure you understand the importance of the theme being addressed. Your particular contribution will be highly valuable and significant to the value of the findings.

If you require any further information or have any questions you can contact me on 086 8157296.

Yours sincerely

Patrick Glackin
DBA Student/ Researcher

Appendix 4 Information sheet sent to focus group participants

Dear [name of participant]

Thank you for agreeing to take part in my research project. Before we meet for the focus group, I want to use this opportunity to inform you a little more about my research study.

I am currently undertaking a professional doctorate in business administration at Northumbria University and this research study is part of my thesis and contribution to practice.

The purpose of this study is to investigate the need for regulation of Healthcare Assistants in Ireland. I plan to conduct a focus group with a selection of participants to explore the following themes:

- ♦ The nature of the HCA role
- ♦ Relationships with other healthcare workers
- ♦ Risks and patient safety
- ♦ Proposed professional regulation

The focus group interview will take approximately 1 hour and will be held in Room 1. Academic Centre, Connolly Hospital, Blanchardstown.

The focus group will be taped and then transcribed. Your name will not be recorded on the audio or the transcripts. Your participation will be on a voluntary basis and will be free to withdraw from the research at any time.

To maximise the opportunity for you to take part in the research, transcripts of the interview will be made available to you for further clarification/consultation.

All the data gathered in this study will be treated with strict confidentiality and stored securely and anonymously in accordance with Northumbria University Data Protection and Safe Storage of Research Data Policy and the Irish Data Protection Act 1988 and (Amendment) Act 2003. The transcriptions will be held electronically and encrypted for added security.

The information you provide will not be made available to anyone outside the study. All data will be destroyed after publication by Northumbria University. This is anticipated to be about three years. If at any time you are unhappy with the process outlined or how the focus group is being conducted you can contact Professor Ron Beadle, Northumbria University on 0044 191 227 3469.

Before the focus group commences I will ask you to sign a consent form to confirm that you agree to take part. A copy is attached for your information – I will also bring a copy for you to sign when we meet.

I hope that this gives you an overview of the project, and that you are still happy to participate. Please do let me know if you have any questions – otherwise I look forward to meeting you and the other participants on Thursday, 11th June 2015.

If you require any further information or have any questions you can contact me on 086 8157296.

Yours sincerely

Patrick Glackin
DBA Student/ Researcher

Appendix 5 Information sheet sent to semi-structured interview participants

Dear [name of participant]

Thank you for agreeing to take part in my research project. Before we meet for the interview, I want to use this opportunity to inform you a little more about my research study.

I am currently undertaking a professional doctorate in business administration at Northumbria University and this research study is part of my thesis and contribution to practice.

The primary research aim of this study is to examine the requirement and extent for professional regulation of Healthcare Assistants in the Republic of Ireland.

To support my primary aim I have 4 main objectives:

The objectives of the research are to:

1. Undertake an in-depth critical review of the extant published literature regarding unregistered HCA staff and the relevant discourse regarding professional regulation
2. Seek to understand the views of the healthcare assistants in respect of future regulation for their profession
3. Assess the views of other key stakeholders in Ireland in respect of proposed introduction of healthcare assistant regulation
4. Identify the risks if any associated with this workforce continuing to provide front line clinical care while unregulated

During the interview I wish to explore your views in respect of requirements for professional regulation of healthcare assistants working in the Irish Health Service. Areas of focus will include the following:

- ◆ Expanded roles
- ◆ Protecting the public
- ◆ Recent high profile inquiries
- ◆ Risks and proportionate response
- ◆ Governance for regulation if required
- ◆ Financial cost

The interview will take approximately 45 minutes and I can come and meet you at your office.

The interviews will be taped and then transcribed. Your name will not be recorded on the audio or the transcripts. Your participation will be on a voluntary basis and will be free to withdraw from the research at any time.

To maximise the opportunity for you to take part in the research, transcripts of your interviews will be made available to you for further clarification/consultation.

All the data gathered in this study will be treated with strict confidentiality and stored securely and anonymously in accordance with Northumbria University Data Protection and Safe Storage of Research Data Policy and the Irish Data Protection Act 1988 and

(Amendment) Act 2003. The transcriptions will be held electronically and encrypted for added security.

The information you provide will not be made available to anyone outside the study. All data will be destroyed after publication by Northumbria University. This is anticipated to be about three years. If at any time you are unhappy with the process outlined or how the interview is being conducted you can contact Professor Ron Beadle, Northumbria University on 0044 191 227 3469.

Before the interview I will ask you to sign a consent form to confirm that you agree to take part. A copy is attached for your information – I will also bring a copy for you to sign when we meet.

I hope that this gives you an overview of the project, and that you are still happy to participate. Please do let me know if you have any questions – otherwise I will be in touch soon to arrange a time for us to meet.

Appendix 6 Letter of thanks/covering letter with transcripts to all participants

Title-Name

Address I

Address2

Address 3

Address4

Date:

Date xxx

Re: Focus Group/In-depth Interview

Dear [Name of participant]

Thank you once again for your valuable contribution to my study on the requirement for regulation of HCAs in Ireland. I have completed the transcription of the discussion at the Focus Group/in-depth interview on xxxx 2015 in [name of location].
I have attached a copy of the transcript for your feedback on accuracy.

I wish to reiterate that your contribution will remain confidential and anonymous. All the information will be stored securely.

If you require any further information or have any questions you can contact me on 086 8157296. You can return suggested changes to my secure work address; Nursing and Midwifery Planning and Development, HSE, 1st Floor, Scott Building, Midland Regional Hospital Tullamore Campus, Arden Road, Tullamore, Co. Offaly. Alternatively, you can email changes to patrick.glackin@hse.ie.

I look forward to hearing from you.

Yours sincerely

Patrick Glackin
DBA Student/ Researcher

Appendix 7 Ethics Approval from Northumbria University for my research

From: Rachel Barr [r.barr@northumbria.ac.uk]

Sent: 22 April 2014 11:21

To: patrick.glackin

Subject: DBA Ethical Approval

Attachments: image002.jpg

Hi Patrick,

I am pleased to advise that your project has now received ethical approval from the Faculty Research Ethical Approvals Panel. The only recommendation from the panel is as follows:-

'The only issue that we need to confirm is that as this research involves health issues we should get written confirmation from the student that all internal ethical issues relating to the Irish Health and Safety Executive are being followed. This could be confirmed in his application.'

If you have any queries, please do not hesitate to contact me.

Best wishes,

Rachel

Rachel Barr

Faculty Support Administrator, Faculty of Business and Law

Appendix 8 Organisational Ethics Approval from Health Service Executive, Ireland for my research



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive



Merlin Park University Hospital
Ospidéal na h-Ollscoile, Páirc Mheirlinne
GALWAY UNIVERSITY HOSPITALS

Clinical Research Ethics Committee
Main Administration Building
Merlin Park Hospital
Galway.

26th September, 2014.

Mr. Patrick Glackin
Area Director of Nursing & Midwifery Planning
& Development Unit
Block 4
Central Business Park
Clonminch
Tullamore
Co. Offaly.

Ref: C.A. 1142 – Professional Regulation for Healthcare Assistants in Ireland

Dear Mr. Glackin,

I have reviewed and considered the above project, and I wish to grant Chairman's approval to proceed.

Yours sincerely,

pp 
Dr. Shaun T. O'Keeffe
Chairman Clinical Research Ethics Committee.

Merlin Park University Hospital, OSPIDÉAL NA H-OLLSCOILE, PÁIRC MHEIRLINNE,
Galway, Ireland. Tel: 00 353 (0)91 757631

Appendix 9 Demographic profile of HCA focus group respondents

Demographic profile of HCA focus group participants (n = 34)			
<i>Demographic detail</i>	<i>Category</i>	<i>Number</i>	<i>Percentage</i>
Age group (years)	18 – 30	2	6
	31 – 40	8	23
	41 – 50	10	30
	51 – 60	14	41
	Over 60	0	0
Gender	Male	7	21
	Female	27	79
Type of employing organisation	HSE	30	88
	Voluntary	1	3
	Private	3	9
Area of work practice	Acute General Hospital	6	18
	Mental Health	8	23
	Disabilities	1	3
	Older Persons	12	35
	Midwifery	1	3
	Community	5	15
	Hospice	1	3
Total time as HCA	Less than 5 years	4	12
	5 to 10 years	14	41
	More than 10 years	16	47
Has FETAC Level 5 Qualification	Yes	31	91
	No	3	9

Appendix 10 HCA focus group interview schedule



Introduction

Personal Introduction and background

Purpose of the research

- ◆ Brief overview of professional regulation
- ◆ Background and Rationale
- ◆ Policy Context
- ◆ Objectives

Permission- sign consent form; agree to taping

Agree on follow-up if needed

	Questions	Probe For
1.	<p>How has the role of the HCA changed since it was first introduced in 2001?</p> <p>What in your opinion are the main changes?</p>	<ul style="list-style-type: none"> ◆ Take more responsibility ◆ Expected to do more ◆ Shift from relief worker to substitute ◆ Boundaries ◆ Blurring of roles ◆ Working beyond parameters ◆ More invasive care ◆ Not allowed to fulfil the work role ◆ How does this make you feel?
2.	<p>What in your opinion distinguishes the role of the HCA from that of a registered nurse or midwife?</p> <p>Do you feel there is clarity between the various roles and responsibilities of nurses and HCA staff working across the Irish Health Service?</p>	<ul style="list-style-type: none"> ◆ Identity badges ◆ Uniforms ◆ Confusion with public/patients ◆ Tasks ◆ Dirty work ◆ Role blurring
3.	<p>At this point I would like to hear your views on how well HCAs are currently prepared to fulfil their role in the health service?</p>	<ul style="list-style-type: none"> ◆ Requirement for changes in the provision of education ◆ Experience
4.	<p>Can you identify the supports for you in your role as HCAs and the value of those supports?</p>	<ul style="list-style-type: none"> ◆ Supervised/unsupervised ◆ Team working ◆ Lone working

		<ul style="list-style-type: none"> ◆ Helped ◆ Tensions ◆ Criticised ◆ Not included in handovers ◆ Ignored ◆ Degradation ◆ Opportunities for Education/competence ◆ Feel valued ◆ Rewarded/praised ◆ Pay
5.	How would you describe the relationships between HCAs and other professionals (nurses, midwives, AHPs, doctors) in the delivery of health services?	<ul style="list-style-type: none"> ◆ Tensions ◆ Workload ◆ Delegation ◆ Supervision ◆ Accountability ◆ Dirty work
6.	What type of patient information do you as HCAs have access to?	<ul style="list-style-type: none"> ◆ None ◆ Limited ◆ Handovers ◆ Patient charts ◆ Personal data ◆ Diagnosis ◆ Care plans
7.	<p>What in your opinion are the pros and cons of professional regulation for</p> <p>1. HCAs</p> <p>2. Public/Patients</p> <p>3. Health Service/Employer</p>	<p>1. HCAs (identity, status, pay, career pathway, CPD, self interest, clarity of role)</p> <p>or</p> <p>disproportionate response to the risk presented, cost of registration, achieving higher standards of education, restrictions on role parameter, barrier to access the role, fitness to practice hearings</p> <p>2. Public/Patient (reduced risk, increased trust/confidence, less adverse incidents, public interest)</p> <p>or</p> <p>Cost of registration of HCAs may be passed to the taxpayer, Cost of care may increase,</p> <p>4. Irish Health Service (Reduced risks, enhanced</p>

		<p>reputation, fewer complaints, patient outcomes, standards, clarity of role for other professionals, greater trust in the role and quals of HCAs, delegation of duties, supervision and accountability)</p> <p>or</p> <p>Irish Health Service (less flexibility in recruiting HCAs, cost of employing HCAs may increase,</p>
8.	How has recent high profile inquiries influenced your practice and your views on regulation?	<ul style="list-style-type: none"> ◆ Mid-Staff ◆ Aras Attracta ◆ Portlaoise Maternity ◆ Winterbourne View
9.	<p>What in your opinion are the risks if the role remains un-regulated?</p> <p>Or threats to the quality of patient care</p>	<ul style="list-style-type: none"> ◆ Education & training not standardised and regulated. ◆ HCAs working to different standard nationally ◆ Role is context specific ◆ HCA cannot be struck off a register (can seek employment elsewhere)
10.	<p>Should HCAs be regulated in Ireland and why or why not?</p> <p>If so, who should regulate the HCAs?</p>	<ul style="list-style-type: none"> ◆ No disproportionate response ◆ No risk ◆ Public Protection

Appendix 11 Interview themes informed by the literature

Interview Theme	Literature
The nature of the HCA role (including role clarity, evolving role, preparation for the role, role substitution).	Government of Ireland (1998); Thornley (2000); Stokes and Warden (2004); HSE (2006); Hogan (2006); Bach et al. (2008); Flood (2008); Thornley (2008); Oldman (2009); Oldfield (2009); Kessler et al. (2010); O'Driscoll et al. (2010); Hasson and McKenna (2011); Department of Health UK (2012); McIntosh and Holland (2012); Berta et al. (2013); Cavendish (2013); Hasson et al. (2013); Duffield et al. (2014); HSE (2013); HSE (2014); Munn et al. (2013); McLoughlin (2014); Hewko et al. (2015).
Lone worker (HCAs providing home care for patients in their own home)	Badger et al. (1989); Taylor and Donnelly (2006); Health and Safety Authority (2011); Bach et al. (2012); HSE (2012); O'Shea (2013); Spilsbury et al. (2013); Tourangeau et al. (2014); Migrant Rights Centre (2015).
Relationships with other healthcare workers (including supervision, delegation and accountability)	Daykin and Clarke (2000); Thornley (2000); British Association of Critical Care Nurses (2003); Spilsbury and Meyer (2004); Keeney et al. (2005); Bosley and Dale (2008); Alcorn and Topping (2009); Kalisch et al. (2009); Oldfield (2009); Kessler et al. (2010); Moran et al. (2011); Shannon (2012); Cavendish (2013); Mueller and Vogelsmeier (2013); Munn et al. (2013); Fealy et al. (2014); McLoughlin (2014); McMullen et al, 2015; Nursing and Midwifery Board of Ireland (2015).
Risks and patient safety (Preparation, recent investigations and inquiries)	McKenna et al. (2004); Centre for Allied Health Evidence (2006); Duffin (2006); Lourdes Hospital Inquiry (2006); Saks and Allsop (2007); Rafferty et al. (2007); Bosley and Dale (2008); Commission of Investigation Ireland (2009); Griffiths and Robinson (2010); HIQA Tallaght Hospital Report (2012); Drennan et al. (2012); Lafferty et al. (2012); Francis (2013); Aiken et al. (2014); Duffield et al. (2014).
Access to information (Handovers, access to patient clinical records, information asymmetry)	Arrow (1963); Graddy (1991); Adams and Tower (1994); Spilsbury and Meyer (2004); Garoupa (2006); Kessler et al. (2010); Nursing and Midwifery Board of Australia (2010); Baldwin et al. (2012); Talty (2013); RCN (2014).
Proposed professional regulation (motivation for regulation, public interest, self interest, paying for regulation)	Johnson et al. (2002); McKenna et al. (2004); Saks and Allsop (2007); Youg (2008); Braithwaite (2010); Griffiths and Robinson (2010); Calkin (2011); Royles (2011); Quick (2011); Glasper (2012); McIntosh and Holland (2012); Braeseke et al. (2013); British Journal of Healthcare Assistants (2013); Francis (2013); Duffield et al. (2014); Vaughan et al. (2014); Hewko et al. (2015).

Appendix 12 Consent form for research participants



Faculty of Business and Law Informed Consent Form for research participants

Title of Study:	An Examination of the Requirement and Extent for Professional Regulation of Healthcare Assistants in the Republic of Ireland.
Person(s) conducting the research:	Patrick Glackin Area Director of Nursing and Midwifery Planning and Development, HSE
Programme of study:	Doctorate of Business Administration (DBA)
Address of the researcher for correspondence:	NMPD HSE Unit 4, Central Business Park Clonminch Tullamore County Offaly
Telephone:	0868157296
E-mail:	Patrick.glackin@hse.ie
Description of the broad nature of the research:	<p>The primary research aim of this study is to Examine the requirement and extent for professional regulation of Healthcare Assistants in the Republic of Ireland. To support the primary aim there are 4 main objectives:</p> <ol style="list-style-type: none"> 1. Undertake an in-depth critical review of the extant published literature regarding unregistered HCA staff and the relevant discourse regarding professional regulation 2. Seek to understand the views of the healthcare assistants in respect of future regulation for their profession 3. Assess the views of other key stakeholders in Ireland in respect of proposed introduction of healthcare

	<p>assistant regulation</p> <p>4. Determine the levels of risk if any associated with this workforce continuing to provide front line clinical care while unregulated</p> <p>The researcher will adopt a qualitative methodological approach consisting of semi structured in-depth interviews and focus groups.</p> <p>Before any data is collected the relevant organisation (Health Service Executive) and all potential participants will be fully informed about the nature of the research. The HSE will be presented with an organisational consent form and you will be given an individual consent form in advance of any data collection. The purpose and context of the research will be explained to you in advance of data collection.</p> <p>The researcher will at all time demonstrate concern for your welfare and protection as a contributor to the research.</p> <p>The research has the potential to make a contribution to both theory and practice of professional regulation. Research already collected has highlighted the challenges associated with healthcare assistants continuing to work as an un-regulated workforce.</p>
<p>Description of the involvement expected of participants including the broad nature of questions to be answered or events to be observed or activities to be undertaken, and the expected time commitment:</p>	<p>The researcher will employ focus groups to explore your views in respect of potential professional regulation for Healthcare Assistants. The aim of the focus group is to encourage you to talk to each other rather than to address yourselves to the researcher.</p> <p>Three focus groups comprising of ten participants per group will be facilitated nationally in three geographical areas; west, south and east. You have been recruited through the Centre for Nurse and Midwifery of Education.</p> <p>Focus groups will be led by an agenda based upon respect, empowerment and equality (Olesen, 2000; Cohen, Manion & Morrison, 2003). The researcher will also engage the services of the healthcare</p>

	<p>assistant education co-ordinators with whom you may be familiar to assist with the facilitation of the focus group sessions.</p> <p>The duration of the focus group will be approximately 90 minutes. Your participation is voluntary and you are free to withdraw from the research at any time. Participants have been recruited from both the private and public health care services representative of hospital, community and primary care services.</p> <p>Areas of focus for the group interviews include:</p> <ul style="list-style-type: none"> ♦ Nature of the HCA role ♦ Relationships with other healthcare workers ♦ Risks and patient safety ♦ Views on potential regulation <p>You will be fully informed about the purpose, methods and intended possible uses of the research, what your participation entails and what risks, if any, are involved.</p> <p>You will participate in a voluntary way, free from any coercion.</p> <p>The interviews will be taped and then transcribed. Your will not be recorded on the audio or the transcripts.</p> <p>To maximise the opportunity for your participation in the research, transcripts of your interviews will be made available to you for further clarification/amendment.</p>
	<p>All the data gathered in this study will be treated with strict confidentiality and stored securely and anonymously in accordance with Northumbria University Data Protection and Safe Storage of Research Data Policy and the Irish Data Protection Act 1988 and (Amendment) Act 2003. Every attempt will be made to ensure that information cannot be linked back to you in any way. All interviews and focus groups will be digitally recorded and then transcribed. The names of the participants will not be recorded on the audio or the</p>

	<p>transcripts.</p> <p>The recordings will only be heard by the researcher for the purpose of the study. If you feel uncomfortable with the recorder, then you may ask that it be turned off at any time.</p> <p>Although the interview will be recorded, your name will not be recorded on the tape. Your name and identifying information will not be associated with any part of the written report of the research. All of the information and interview responses will be kept confidential.</p> <p>Transcripts will only be identifiable by a unique identifier (e.g. code/reference number). The researcher will create two lists to manage the anonymity of the data subjects.</p> <ul style="list-style-type: none"> ♦ The first list will contain the unique identifier next to the names of the participants ♦ The second list will use the same unique identifier against each set of data collected. <p>The two lists will therefore be stored separately, so the list containing the names will be locked away from the data collection list.</p> <p>All data will be kept in a locked cabinet in the researcher's office and on the researcher's computer which is security encrypted.</p> <p>The computer will be locked when the researcher leaves the room.</p> <p>Raw data will not be made available to anyone outside the study.</p> <p>Finally, you will be offered a copy of the interview transcript and provided with the opportunity to take out or amend any part of it that you do not wish to have reported in the findings.</p> <p>Any data collected for the purpose of the proposed research will only be kept for the required duration necessary and will then be disposed via the confidential waste</p>
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	process in HSE.
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Information obtained in this study, including this consent form, will be kept strictly confidential (i.e. will not be passed to others) and anonymous (i.e. individuals and organisations will not be identified *unless this is expressly excluded in the details given above*).

Data obtained through this research may be reproduced and published in a variety of forms and for a variety of audiences related to the broad nature of the research detailed above. It will not be used for purposes other than those outlined above without your permission.

Your participation is entirely voluntary and you may withdraw at any time.

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this study on the basis of the above information.

Participant's signature:

Date:

Student's signature:

Date:

Please keep one copy of this form for your own records

Appendix 13 Semi-structured Interview Schedule



Introduction

Personal Introduction and background

Purpose of the research

- ♦ Brief overview of professional regulation
- ♦ Background and Rationale
- ♦ Policy Context
- ♦ Objectives

Permission- sign consent form; agree to taping

Agree on follow-up if needed

	Questions	Probe For
1.	<p>How has the role of the HCA changed since it was first introduced in 2001?</p> <p>What in your opinion are the main changes?</p>	<ul style="list-style-type: none"> ♦ Take more responsibility ♦ Expected to do more ♦ Shift from relief worker to substitute ♦ Boundaries ♦ Blurring of roles ♦ Working beyond parameters ♦ More invasive care ♦ Not allowed to fulfil the work role ♦ How does this make you feel?
2.	<p>What in your opinion distinguishes the role of the HCA from that of a registered nurse or midwife?</p> <p>Do you feel there is clarity between the various roles and responsibilities of nurses and HCA staff working across the Irish Health Service?</p>	<ul style="list-style-type: none"> ♦ Identity badges ♦ Uniforms ♦ Confusion with public/patients ♦ Tasks ♦ Dirty work ♦ Role blurring
3.	<p>At this point I would like to hear your views on how well HCAs are currently prepared to fulfil their role in the health service?</p>	<ul style="list-style-type: none"> ♦ Requirement for changes in the provision of education ♦ Experience
4.	<p>In my focus groups with HCAs, the respondents at times felt unsupportive and undervalued in their existing roles. In your</p>	<ul style="list-style-type: none"> ♦ Supervised/unsupervised ♦ Helped ♦ Tensions

	opinion is this a fair assessment? How do you respond to this?	<ul style="list-style-type: none"> ♦ Criticised ♦ Not included in handovers ♦ Ignored ♦ Degradation ♦ Opportunities for Education/competence ♦ Feel valued ♦ Rewarded/praised ♦ Pay
5.	How would you describe the relationships between HCAs and other professionals (nurses, midwives, AHPs, doctors) in the delivery of health services?	<ul style="list-style-type: none"> ♦ Tensions ♦ Workload ♦ Delegation ♦ Supervision ♦ Accountability ♦ Dirty work
6.	What type of patient information do you feel HCAs should have access to?	<ul style="list-style-type: none"> ♦ None ♦ Limited ♦ Handovers ♦ Patient charts ♦ Personal data ♦ Diagnosis ♦ Care plans
7.	<p>A key concern raised in the Focus Groups was the standard of HCAs employed through private agencies and contracted or commissioned by the Health Service. How reasonable is this concern?</p> <p>The Migrants Rights Centre Ireland has recently published a paper highlighting concerns about exploitation of migrant workers (HCAs) by Private Home Care providers and subsequent consequences for standards of care. Do you have views on this?</p>	<ul style="list-style-type: none"> ♦ Preparation ♦ Continuity of Care ♦ Lone working ♦ Vulnerable service users
8.	<p>What in your opinion are the pros and cons of professional regulation for</p> <p>1. HCAs</p> <p>2. Public/Patients</p>	<p>1. HCAs (identity, status, pay, career pathway, CPD, self interest, clarity of role)</p> <p>or</p> <p>disproportionate response to the risk presented, cost of registration, achieving higher standards of education, restrictions on role parameter, barrier to access the role, fitness to practice hearings</p> <p>2. Public/Patient (reduced risk, increased trust/confidence, less adverse incidents, public interest)</p> <p>or</p>

	3. Health Service/Employer	<p>Cost of registration of HCAs may be passed to the taxpayer, Cost of care may increase,</p> <p>3. Irish Health Service (Reduced risks, enhanced reputation, fewer complaints, patient outcomes, standards, clarity of role for other professionals, greater trust in the role and quals of HCAs, delegation of duties, supervision and accountability) or</p> <p>Irish Health Service (less flexibility in recruiting HCAs, cost of employing HCAs may increase,</p>
9.	How has recent high profile inquiries influenced the discourse relating to regulation of HCAs?	<ul style="list-style-type: none"> ◆ Mid-Staff ◆ Aras Attracta ◆ Portlaoise Maternity ◆ Winterbourne View
10.	<p>What in your opinion are the risks if the role remains un-regulated?</p> <p>Or threats to the quality of patient care</p>	<ul style="list-style-type: none"> ◆ Education & training not standardised and regulated. ◆ HCAs working to different standard nationally ◆ Role is context specific ◆ HCA cannot be struck off a register (can seek employment elsewhere)
11.	<p>Should HCAs be regulated in Ireland and why or why not?</p> <p>If so, who should regulate the HCAs?</p>	<ul style="list-style-type: none"> ◆ No disproportionate response ◆ No risk ◆ Public Protection

Appendix 14 Member checking exercise to validate findings

**30th March 2016
2pm – 3:30pm
Mansion House, Dublin**

On the 30th March 2016, I was invited to give an update on my findings to HCA members of the SIPTU trade union. I used this opportunity to provide a brief overview of my initial interpretations of HCAs perspectives on the potential of professional regulation for their occupational group. The HCA members at this meeting included participants from the earlier focus groups as well as HCAs who had not contributed to the research to date. This was a form of member checking whereby I presented the findings under six key themes to eighteen HCA participants to establish the level of agreement between my own interpretations and the accounts provided by participants. The six key themes were as follows:

1. Perceptions on the Evolving Role of the HCA in Ireland;
2. Preparation for the role;
3. The impact of the role on quality and patient safety;
4. Opinions on HCAs accessing patient information;
5. The nature of the relationship between HCAs and other health care professionals;
6. Perceived value of professional regulation for HCAs and the public

This is a useful method to bring closer together both the researcher and the respondent's perspectives.

To enhance the credibility of my findings this member checking exercise helped to confirm what was going on in the minds of the participant and the degree to which the participants' views, thoughts, feelings, intentions and experiences are accurately understood by the researcher.

As well as simply allowing for checking of findings, this process has also allowed for error reduction in analysis and the generation of further data which has been included in the study.

I gave a power point presentation of my findings under the six aforementioned themes and encouraged the participants to comment, ask questions or make suggestions throughout the presentation. The participants were generally vocal in their responses to the relevant themes. On the rare occasion when there wasn't a response or a comment I would prompt

the participants by asking ‘Is this what you meant?’ or ‘Is this a fair reflection of your experience?’

Those HCA participants who took part in the Focus Groups claimed to have found the experience ‘interesting’ and ‘valuable’. They expressed a sense of appreciation of being able to voice their experiences and being heard. I will reflect on their feedback under the following key themes:

1. Perceptions on the Evolving Role of the HCA in Ireland

There was overwhelming agreement that the findings expressed under this theme reflected the reality experienced by HCAs and articulated by HCAs during the focus groups. The strength of feeling was particularly strong in respect of the sub-theme ‘unseen work’ whereby HCAs were forthright in their opinion that their work often goes unnoticed and unacknowledged by other professionals. Equally, the sub-theme ‘national uniform and job description’ prompted a palpable response from non-focus group participant HCAs some of whom claim that they do not have a job description whilst others who do have a job description, they claim that it does not reflect the duties and responsibilities of their role.

2. Preparation for the Role

Again, there was a general concurrence with the findings in respect of this theme. The sub-theme ‘concern regarding some education providers’ had particular resonance with some HCAs who were aware of colleagues who had negative experiences with some HCA training providers. The HCA participants also reaffirmed their aspirations to have a career pathway within their occupational group rather than having to enter the nursing or midwifery profession.

3. The impact of the role on quality and patient safety

Some HCA respondents were of the opinion that my interpretation of the HCA perspectives aligned to this theme could be more reflective of the risks associated with the role. One such risk was the undetected rogue practitioner which is referenced in a later theme but is perhaps of more relevance to the message of this theme. One HCA respondent also challenged the requirement to include

‘supervision’ as a sub theme as they felt that they were experienced independent practitioners who did not require supervision to maintain quality and patient safety.

4. Opinions on HCAs accessing patient information

There was a convergence in thinking that the interpretation of the experience of HCAs in respect of access to patient information was variable and context specific. This interpretation was reflected in this respondents validation exercise.

5. The nature of the relationship between HCAs and other HCA professionals

Some HCA respondents who were not involved in the focus groups were of the opinion that the findings relating to the sub-theme ‘teamwork’ did not resonate with their own experiences. They expressed disappointment that I didn’t facilitate a focus group in their geographical area and therefore did not capture their very positive experiences of team work. My interpretation of the data collected was that the comments expressed by the HCAs were variable in relation to working relationships and teamwork which included both positive and negative experiences. This, I believe is reflected in my findings. The comments expressed by these HCAs were, in my view, a manifestation of the frustration of not having the opportunity to voice their opinion through the medium of a focus group and thereby implying (incorrectly) that there was a gap in the findings. The invivo sub-theme ‘just a HCA’ was unanimously accepted as a sub-theme that captured the sense of value and worth placed on the role by other professionals.

6. Perceived value of professional regulation for HCAs and the public

There was general satisfaction with the participants that this theme accurately reflected a representation of their views. Some HCA respondents suggested more emphasis on patient safety and public protection. I believe that this was captured in theme 3, but the comments have prompted me to review the theme. This theme also prompted the HCAs to raise the topic of regulation and the degree of regulation required for their occupational group. They did not believe that they should be subjected to the same rigors of professional regulation as applied to nurses as they do not have the same responsibilities or levels of income to fund same.

Conclusion

Overall, feedback from this member checking exercise has confirmed to me that the findings from my case study research are credible in the eyes of the HCA respondents. They also believed the findings to be ‘very supportive’ in the pursuit of professional regulation. This member checking exercise is therefore deemed to be satisfactory and offers reassurance that a significant level of agreement between my own interpretations and the accounts provided by participants exists.

Appendix 15 Sample showing the development (across five templates) of the theme “Perceived value of professional regulation for HCAs and the public”

Initial Template

Level 2 Category	Level 3 Sub-category	Level 4 Codes
Identity	Career Structures/opportunities	Just a HCA'; 'A pair of hands'; cheap labour; desire for own management structure.
	Equality	Desire for recognition as a HCA; equality with other professionals; desire for separate identity; a sense of own identity.
	Pride	Regulation instils a sense of pride; respect, sense of identity; just a HCA; object of blame.
Preparation for regulation	QQI (FET) Training	Don't fear training; mandatory standards of training
Motivation	Self interest	Career pathway; equality with professionals; enhanced self worth; sense of ambition; regulation brings respect;
	Public interest	No desire for regulation; maintain status quo; scandals; Aras Attracta; remove rogue practitioners;
	Magnetic appeal	Observed the value of regulation for nurses; attract good HCAs;
	Teamwork	Promote team work;
Accountability	Accountability in the absence of regulation	Desire for Accountability; sense of helplessness; object of blame; challenging authority; resentment at nurses responsibility and accountability; questioning the value of regulation
Risks of remaining unregulated	Lack of traceability of rogue practitioners	Risk of patient abuse, national register
	Lack of standards	Aras Attracta; poor practices
Costs and paying for regulation	Paying for regulation	One-off single payment; concerned regarding amount to pay.

Template 2

Level 2 Category	Level 3 Sub-category	Level 4 Codes
Identity	Career Structures/opportunities	Desire for a career pathway; Management structure; remain as a HCA; sense of expectation to be regulated; no interest in a nursing career pathway; Just a HCA'; 'A pair of hands'; cheap labour; desire for own management structure.
	Equality	Desire for recognition as a HCA; equality with other professionals; a sense of own identity; separate umbrella group; regulation would enhance status and sense of worth and value for HCA;

		communication and handovers were significant issues of concern and perceived status vis a vis the nurse; variable access to patient clinical records; desire for separate identity; a sense of own identity.
	Pride	Sense of pride in role, respect, sense of identity, just a HCA, 'I love my job'; 'working ants of the system'; 'treated like a grunt'; self destructive dialogue;
Perceived value of regulation	Role clarity and traceability	Grey areas'; role ambiguity; role confusion; variable practices; lack of role parameters; role confusion with analogous working groups; 'muddled job description'
	Remove rogue practitioners	Imposed sanctions; national register; combat risk; removal of licence to practice;
	Questioning the value	Risk of staff attrition; questioning value for money; more bureaucracy;
Motivation	Self interest	Career pathway; equality with professionals; enhanced self worth; sense of ambition; regulation brings respect; enhance attractiveness as a realistic career option; desire for professional identity.
	Public interest	No desire for regulation; maintain status quo; scandals; Aras Attracta; remove rogue practitioners; rogue practitioners; patient safety; lone worker
	Magnetic appeal	Observed the value of regulation for nurses; attract good HCAs;
	Teamwork	Promote team work; would become a valued team member; inclusion in handovers; access to patient clinical records
Accountability	Safe practice standards, competence and qualifications	Aras Attracta; eradicate poor practices;
	Desire for greater accountability	Sense of helplessness; object of blame; challenging authority;
	Accountability in the absence of regulation	Desire for Accountability; resentment at nurses responsibility and accountability; questioning the value of regulation
Risks of remaining unregulated	Lack of traceability of rogue practitioners	Risk of patient abuse, national register
	Lack of standards	Aras Attracta; poor practices; low barrier to entry; variable work practices; no standards on behaviour and conduct;
Costs and paying for regulation	Paying for regulation	One-off single payment; concerned regarding amount to pay; affordability;
	Administrative costs	Not the same as nurses; similar costs to PHECC
	Bureaucracy	Paper work; costs;

Template 3

Level 2 Category	Level 3 Sub-category	Level 4 Codes
Identity	Career structure/opportunities	Desire for a career pathway; Management structure; remain as a HCA; sense of expectation to be regulated; no interest in a nursing career pathway. Just a HCA'; 'A pair of hands'; cheap labour; desire for own management structure
	Equality	Desire for recognition as a HCA; equality with other professionals; desire for separate identity; a sense of own identity; separate umbrella group; regulation would enhance status and sense of worth and value for HCA; questioning preparation for the role; communication and handovers were significant issues of concern and perceived status vis a vis the nurse; variable access to patient clinical records
	Pride	Regulation instils a sense of pride; respect, sense of identity; just a HCA; object of blame; Sense of pride in role, respect, sense of identity, just a HCA, 'I love my job'; 'working ants of the system'; 'treated like a grunt'; self destructive dialogue.
	Voice	Escalate concerns; unheard group; representative voice; patient advocate
Perceived value of regulation	Role clarity and traceability	'Grey areas'; role ambiguity; role confusion; variable practices; lack of role parameters; role confusion with analogous working groups; 'muddled job description'; risk of patient abuse; national register; lack of traceability; desire for more transparency.
	Remove rogue practitioners	Imposed sanctions; national register; combat risk; removal of licence to practice; patient safety; public interest
	Employer led controls	Employment checks, security vetting; reference checks; health screening;
	Questioning the value	Risk of staff attrition; questioning value for money; more bureaucracy; no desire for regulation
Motivation	Self interest	Career pathway; equality with professionals; enhanced self worth; sense of ambition; regulation brings respect; enhance attractiveness as a realistic career option; desire for professional identity.
	Magnetic appeal	Observed the value of regulation for nurses; attract good HCAs;
	Teamwork	Promote team work; would become a valued team member; inclusion in handovers; access to patient clinical records
Accountability	Safe practice standards and competence	Aras Attracta; eradicate poor practices;
	Desire for greater accountability	Desire for Accountability; sense of helplessness; object of blame; challenging authority; resentment at nurses

		responsibility and accountability;
Risks of remaining unregulated	Lack of traceability of rogue practitioners	Risk of patient abuse, national register
	Lack of standards	Aras Attracta; poor practices; low barrier to entry; variable work practices; no standards on behaviour and conduct;
Costs and paying for regulation	Paying for regulation	One-off single payment; concerned regarding amount to pay; affordability; consistent with ability to pay.
	Administrative costs	Not the same as nurses; similar costs to PHECC
	Bureaucracy	Paper work; costs;
Propose organ of administration	Independent	Independent statutory body, not aligned to nursing; not beholden to nursing
	NMBI	Too expensive, beholden to nursing; part of the nursing family
	CORU	Most appropriate for HCAs; too expensive; costs prohibitive
	Other	PHECC

Template 4

Level 2 Category	Level 3 Sub-category	Level 4 Codes
Public Interest	Rogue practitioners	Some HCAs more motivated by money at the expense of caring; barrier to entry to HCA qualification too low; QQI level 5 training too easy; HCAs exhibiting poor practices; lack of traceability of HCAs, national register of HCAs required; patients experiencing difficulty in evaluating quality of care; regulation to eliminate rogue practitioners.
	Preparation for the Role	No mandatory training for HCAs; variability in education and training; inconsistent standards; restrictive learning environment; lack of continuous professional development opportunities; patient entitled to competently trained HCAs; higher risk for lone workers and patients in their own homes; nationally agreed standards in training for HCAs would enhance public confidence.
	Standards of Practice	Increased reliance on HCAs; quality of care compromised; inconsistent standards of practice; Aras Attracta scandal; poor practices; patient safety; challenges of supervision.
	Accountability	Confused accountability between HCAs and registered nurses; task delegation impaired; lack of 'trust'; HCAs desire for accountability for own practice and decisions; protection of the interest of the registered nurse;
	Role clarity and traceability	'Grey areas'; role ambiguity; role confusion; variable practices; lack of role parameters; role confusion with analogous working groups; 'muddled job description'; risk of patient abuse; national register; lack of traceability; desire for more transparency.
Self Interest	Career aspirations and rewards	Desire for professional identity; meaningful role; limited opportunities

		for career progression; sense of disheartenment; no interest in a nursing career pathway; management career pathway; sense of marginalisation; 'I'm just a HCA'; enhance attractiveness as a realistic career option; equality with professionals; enhanced self worth; sense of ambition; regulation brings respect
Proposed regulatory governance	Proposed organ of administration	Nursing and Midwifery Board of Ireland; HCA role part of nursing family; beholden to nursing; CORU; Pre-hospital Emergency Care Council; new regulatory authority; Department of Health responsibility.
	Risk of remaining unregulated	Lack of traceability of rogue practitioners; Risk of patient abuse, national register
	Costs of Regulation	HCA meet own costs of registration; employer pays costs; fair and aligned to income and ability to pay;

Final Template

Level 2 Category	Level 3 Sub-category	Level 4 Codes
Public Interest	Rogue practitioners	Some HCAs more motivated by money at the expense of caring; barrier to entry to HCA qualification too low; QQI level 5 training too easy; HCAs exhibiting poor practices; lack of traceability of HCAs, national register of HCAs required; patients experiencing difficulty in evaluating quality of care; regulation to eliminate rogue practitioners.
	Preparation for the Role	No mandatory training for HCAs; variability in education and training; inconsistent standards; restrictive learning environment; lack of continuous professional development opportunities; patient entitled to competently trained HCAs; higher risk for lone workers and patients in their own homes; nationally agreed standards in training for HCAs would enhance public confidence.
	Standards of Practice	Increased reliance on HCAs; quality of care compromised; inconsistent standards of practice; Aras Attracta scandal; poor practices; patient safety; challenges of supervision.
	Accountability	Confused accountability between HCAs and registered nurses; task delegation impaired; lack of 'trust'; HCAs desire for accountability for own practice and decisions; protection of the interest of the registered nurse;
Self Interest	Career aspirations and rewards	Motivation, desire for professional identity; meaningful role; limited opportunities for career progression; sense of disheartenment; no interest in a nursing career pathway; management career pathway; sense of

		marginalisation; 'I'm just a HCA'; enhance attractiveness as a realistic career option.
Proposed regulatory governance	Proposed organ of administration	Nursing and Midwifery Board of Ireland; HCA role part of nursing family; beholden to nursing; CORU; Pre-hospital Emergency Care Council; new regulatory authority; Department of Health responsibility.
	Costs of Regulation	HCA meet own costs of registration; employer pays costs; fair and aligned to income and ability to pay;

Appendix 16 Job Description of Health Care Assistant

Introduction

The role of the HCA is to support the delivery of patient care under the supervision and direction of qualified nursing personnel (Shannon et al., 2001).

Nursing has been defined as *"The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best quality of life, whatever their disease or disability, until death"* (Royal College of Nursing, 2003). The difference between the registered nurse and the health care assistant is in the knowledge that is the basis of the assessment of need and the determination of action to meet the need, plus the clinical judgement inherent in the processes of assessment, diagnosis, prescription and evaluation.

Educational qualifications:

The recognised qualification for Health Care Assistants is the FETAC (NCVA Level 5) Healthcare Support Certificate.

Staff engaged in the role of Health Care Assistant but have not yet completed this programme will continue in their role and the agreed job description will apply to them. This cohort together with all newly recruited Health Care Assistants will be required to undertake the programme as soon as it can be available to them.

It is recognised that in exceptional circumstances individual staff members may not be in a position to undertake and complete the programme and in this context the job description will apply consistent with the appropriate delegation of duties from the nurse / midwife.

Title

The title Health Care Assistant (H.C.A.) should be used nationally.

Responsibility

There is a clear report relationship between the Health Care Assistant and the Clinical Nurse Manager or their deputy.

Accountability

Health Care Assistants are accountable for their actions in the delivery of patient care and must not undertake any duty related to patient care for which he/she is not trained, in accordance with the educational qualifications outlined above.

The Health Care Assistant must report to and work under the supervision and direction of a Registered Nurse in relation to their duties/tasks and must be integrated into the ward/area team.

Nursing staff will delegate duties in accordance with their professional judgement and within the competence of the Health Care Assistant.

Nursing staff must not allocate any duty to the Health Care Assistant for which he/she has not been trained.

Key Activities

Patients/clients may require assistance in some or all activities of daily living. It is the duty of the nurse to assess, plan, implement and evaluate the care required by the patient. The primary role of

the Health Care Assistant is to assist the nurse in the implementation of the care, as determined by the Registered Nurse.

Duties assigned to the Health Care Assistant will vary depending on the care setting and will include the following functions. This is not an exhaustive list.

- To carry out assigned and delegated tasks involving direct care and all activities of daily living under the supervision of a Registered Nurse (e.g. to assist clients, maintain standards of personal hygiene, laundry, dietary intake, physical and mental health).
- Assisting the Registered Nurse in the provision of quality nursing service by promoting and adopting a philosophy of care within the service area.
- Assisting the Registered Nurse in duties associated with the delivery of care and management of the ward/healthcare environment and other support duties as appropriate.
- To report any incident or potential incident which may compromise the health and safety of clients, staff or visitors and take appropriate action.
- Health Care Assistants should conduct themselves in a manner that conveys respect of the individual and ensures safe patient care. The personal characteristics that indicate these principles should include:
 - Confidentiality
 - Courtesy
 - Accountability
 - Communication
 - Dignity and privacy
 - Health and safety

References

Royal College of Nursing (2003) *"Defining Nursing"*
<http://www.rcn.org.uk/downloads/definingnursing/definingnursing-a5.pdf>

Shannon, M. et al. (2001) *"Effective Utilisation of Professional Skills of Nurses and Midwives: Report of the Working Group"*. Dublin: Department of Health and Children, Brunswick Press.